MQAC[redacted]SE MANAGEMENT TEAM ASSES[redacted]MENT

Wednesday CMT – Telephonic Assessment

Respondent: Medical Unknown **Case Number:** 2011-153821

Date: 4-27-11	Staff Attorney: Mager	Clerk: Newman
Panel Chair:	Cullen, Andison, Brantner, Burger, Clower, Concannon, Elders, Green, Johnson, Pattison, Tobin, Dore, Gothold, Harder, Harvey, Hensley, Hopkins, Page, Robins, Ruiz, Sen	
Staff Present:: ED, ISU, PM, Staff Atty, Disc Mgr, Other	Jansen, Dr. Heye, Smith, Newman, Kramer, Creighton, Farrell, Berg, Caille, McLaughlin, Landreau, Mager	

A. FILE CLOSED PRIOR INVESTIGATION (BEFORE)

☐ **BT1** - Advertising that is a technical violation	☐ **BT7** - Insufficient information	☐ **BT12** - Profession-Specific Threshold Explain:_____ a) Violating confidentiality b) Inappropriate delegation to unlicensed person that does not involve invasive procedures or piercing of skin (e.g., RN instructs NA to apply skin cream) c) Failure to supervise resulting in no harm or minor harm to a patient d) Isolated incidents which suggest little or no patient harm, not likely to reoccur
☐ **BT2** - Aged or outdated complaints	☐ **BT8** - Issues which have been otherwise resolved. Explain resolution:_____ (Detail corrective action: practitioner is already revoked; ongoing monitoring, etc.)	☐ **BT13** - Referral to another program or agency
☐ **BT3** - Billing and fee disputes except as designated by disciplining authority	☐ **BT9** - Lack of complaint credibility	☐ **BT14** - Risk minimal, not likely to reoccur
☐ **BT4** - Communication and personality issues	☐ **BT10** - No Jurisdiction	☐ **BT15** – Time practice on an expired credential for a period of time accepted by the disciplining authority
☐ **BT5** - Complainant withdrew	☐ **BT11** - No violation at the time the event occurred	☐ **BT16** – Unidentified complainant, client or patient name and no allegations of significant harm or potential harm
☐ **BT6** - If allegations are true, no violation of law occurred		Further explanation (if any):

B. SCOPE OF INVESTIGATION AUTHORIZED: ☐ Entire complaint ☐ Limit investigation ☐ Focus investigation

Notes: _____

C. PRIORITY ☐ A (risk of immediate danger) ☐ B (serious risk) ☐ C (moderate risk ☐ D (minor risk) ☐ E (technical violations)

D. SEXUAL MISCONDUCT CASES: Refer complaints of sexual misconduct to the Secretary when the case does not involve clinical expertise or standard of care issues. (*If the panel cannot tell if clinical issues exist, the panel may request the investigator contact the complainant or key witness)*

☐ Panel finds there are clinical issues, do not refer ☐ No clinical issues, refer case to Secretary ☐ Contact complainant or witness for more Info

E. CLOSED AFTER INVESTIGATION

☐ Application investigation only - Panel decides to grant without conditions	
☐ A1-Care rendered was within standard of care	☐ A7-Mistaken identity
☐ A2-Complainant withdrew-	☐ A8-No Jurisdiction
☐ A3- Unique closure (panel must explain)	☐ A11-No Whistleblower
☐ A5- Evidence does not support a violation	☒ **A12**-Risk minimal, not likely to reoccur
Further Explanation:	

MQAC CMT Assessment (yellow) mlf 0812—2010
04/13/11

GUIDE FOR CLOSURE CODES

June 2010

Code	Closure	Description
	Application	Decision to grant an unrestricted license.
A-1	Care rendered was within standard of care	The evidence establishes that the respondent met or exceeded the standard of care.
A-2	Complainant withdrew complaint	The complainant withdrew the complaint, and the complainant's testimony is necessary to meet the burden of proof.
A-3	Unique closure (Panel must explain)	Any concerns regarding Respondent have been resolved through corrective action, license revocation, suspension, or other means. • Respondent died. • Other circumstances (explain): _____ _____ _____
A-5	Evidence does not support a violation	• Cannot establish by clear, cogent, and convincing evidence that Respondent violated any UDA provision. • Includes situations where the investigator was unable to obtain all material evidence. • Despite the evidence, the alleged misconduct does not constitute a UDA violation.
A-7	Mistaken Identity	Case opened under the wrong respondent's name.
A-8	No Jurisdiction	Respondent is not licensed in Washington, has never been licensed in Washington, and is not applying for a license in Washington.
A-11	No Whistleblower Release	Complainant would not sign a whistleblower release AND the complainant's identity is necessary to prove a UDA violation.
A-12	Risk Minimal- Not likely to Reoccur	There is sufficient evidence that Respondent violated the UDA, but the evidence indicates that (a) the violation is not likely to reoccur and (b) closure poses no more than a minimal risk to the public.

zdan guldeclosecode revised pjh0521-2010

Case View Screen [update]

Case	2011-153821 (PUBLIC)	Date Created	02/14/2011	Audit	
Status	CLOSED	Date Received	02/14/2011	Entry Items	
		How Received	Mail	Documents	
Respondent ID	232147	Receiving Board	COMMISSION	Notes	
Respondent	UNKNOWN MEDICAL	Receiving Profession	Physician And Surgeon License	Master Cases	
		Receiving Department	Case Intake	Participants	
Complainant ID	982094	Received By	Cynthia R Hamilton	Add Master Case	
Complainant	Ron and Valerie Foulds Jr	Alleged Issues		Timeline History	
		Error in Prescribing, Dispensing or Administering Medication			
		Patient Care			
		Case Nature			
		Standard of Care/Services			

Comments:

- Priority History
- Other Participants
- Resolution
- HIPDB Reports
- TimeTracker
- Action Items

Priority History [add]

Date	Priority	Priority Reason	Decision Maker	Decision Date	Comment	COR	User
Mar 3 2011 10:00AM	C Priority	Standard of Car...	Medical Commission	02/23/2011		NO	Creighton, Vicki I

Other Participants [add]

No additional participants found

Resolution [update]

Department:	Case Management	Found Issues	
Worker:	Angela M Bucci	None	
Date Closed:	04/27/2011	Resolution	
		Risk minimal, not likely to reoccur	

Resolution Notes:

Current HIPDB Reports

Type	Submission Date	Status	DCN	Case ID

No HIPDB Reports found for this credential.

Time Tracker

Charge Back Totals

Department	Hours	Amount

Cost Recovery Totals

Department	Hours	Amount

Cost Recovery Invoicing

Respondent	InvoiceDate	User

Action Items [add] [add group]

Type	Assigned To	Activity	Track Time	Due	Effective	Completed	Order Signed	Created ▼	User
Change Status to Closed	Case Management, Legacy				04/27/2011	04/27/2011		04/27/2011	Bucci, Angela M
Target:	UNKNOWN MEDICAL								
Case Status:	Status Changed To: CLOSED								
Action Info:	Resolution Recorded? Yes								
Comments:	Closed A-12								
Present for Assessment	Case Management, Bucci, Angela M				04/27/2011	04/27/2011		04/27/2011	Bucci, Angela M
Target:	UNKNOWN MEDICAL								
Action Info:	Decision Date 04/27/2011								
	CMT Decision Maker 1 Gotthold William								
	CMT Decision Maker 2 Hopkins Bruce								
	CMT Decision Maker 3 Tobin Judy								
	CMT Decision Maker 4 Elders Theresa								
	CMT Decision Maker 5 Mager Suzanne								
	CMT Decision Maker 6 Heye George								
	CMT Decision Maker 7 Smith Jim								
	CMT Decision Maker 8 Creighton Vicki								
	CMT Decision Maker 9 Newman Dani								

Comments:	Closed A-12					
Forward for Case Manager Review Invest Complete	Case Management, Bucci, Angela M	[add]	03/31/2011	03/31/2011	03/31/2011	Creighton, Vicki1
Target:	UNKNOWN MEDICAL					
Case Status:	Status Changed To:	Case Disposition				
Investigative Forward for Closure of Investigation	Investigation Supervisor, Smith, James H	[add]	03/31/2011	03/31/2011	03/31/2011	Creighton, Vicki1
Assign Investigator	Investigation, Pyles, Connie	[add]	03/09/2011	03/09/2011	03/09/2011	Creighton, Vicki1
Target:	UNKNOWN MEDICAL					
Action Info:	Priority Set and Entered?	Yes				
File Location	Investigation, Creighton, Vicki I		02/23/2011	03/09/2011	03/09/2011	Creighton, Vicki I
Target:	UNKNOWN MEDICAL					
Comments:	Awaiting WBW - due 3/10/11 3/9/11 WBW received					
Investigative Correspondence - General	Investigation, Creighton, Vicki I	[add]	02/24/2011	02/24/2011	02/24/2011	Creighton, Vicki I
Target:	UNKNOWN MEDICAL					
Comments:	2-25-2011 Acknowledgement & whistleblower waiver letters mailed					
Forward for Investigation	Investigation Supervisor, Smith, James H		02/23/2011	02/23/2011	02/24/2011	Creighton, Vicki I
Target:	UNKNOWN MEDICAL					
Case Status:	Status Changed To:	Investigation				
Present for Assessment	Case Management, Creighton, Vicki I		02/14/2011	02/23/2011	02/24/2011	Creighton, Vicki I
Target:	UNKNOWN MEDICAL					
Case Status:	Status Changed To:	Assessment				
Action Info:	Decision Date	02/23/2011				
	CMT Decision Maker 1	Dore Frederick				
	CMT Decision Maker 2	Harvey Susan				
	CMT Decision Maker 3	Tobin Judy				
	CMT Decision Maker 4	Elders Theresa				
	CMT Decision Maker 5	McLaughlin Jim				
	CMT Decision Maker 6	Heye George				
	CMT Decision Maker 7	Smith Jim				
	CMT Decision Maker 8	Newman Dani				
Present for Assessment	Case Management, Hamilton, Cynthia R		02/14/2011	02/23/2011	02/14/2011	Hamilton, Cynthia R
Target:	UNKNOWN MEDICAL					
Case Status:	Status Changed To:	Assessment				
Intake	Case Intake, Hamilton, Cynthia R		02/14/2011	02/14/2011	02/14/2011	Hamilton, Cynthia R
Target:	UNKNOWN MEDICAL					
Warning:	Warning Type:	CASE PENDING				
	Warning Effective Date:	02/14/2011				
	Suppress License Print:	NO				
Case Status:	Status Changed To:	Intake				
Action Info:	Complaint Source	Family Member				
	Possible Imminent Danger?	No				
	Single Complaint Process Coordination Needed?	No				

POST INVESTIGATION REVIEW
Case Number: 2011-153821

***Date: 4-14-2011**

Date: February 14, 2011
Presented by: **George Heye, MD**

Respondent:	**MEDICAL, UNKNOWN**	**Grays Harbor County**

Complainant:	**Ron and Valerie Foulds, Jr.**

CASE SUMMARY

The Respondent:

Board Certified:	Unknown
DOB:	Unknown
Licensed since:	Unknown
Expiration date:	Unknown
Medical School:	Unknown
Residency:	Unknown

The Complainant: The son and daughter-in-law of a patient

The Complaint: The complainants think that the 90 y/o father received a medication not prescribed for him which caused him to become unresponsive and hypotensive. He was treated at a local hospital where he reportedly tested positive for narcotics which are not part of his normal medication regimen.

***Post Investigation Review: 4-14-2011**

A 90y/o nursing home resident who was usually mentally alert was found just before midnight to be obtunded and with shallow respirations. 911 was called and the patient responded briefly to Narcan. The patient was taken to a local hospital where he received additional Narcan and was admitted. The patient required intubation and blood pressure support. He remained on the ventilator for a day and a half and then maintained well without it. The patient reportedly grew MRSA staph from his urine and was treated with antibiotics. He was discharged back to the nursing home on day five but his mental clarity was still variable.

A urine test on admission was positive for oxycodone. A repeat test was also positive. The patient was not on any narcotic medication at the nursing home. An extensive investigation at the nursing home failed to turn up any missing medication or any explanation for the oxycodone in the patient's urine. There was some speculation that the patient's symptoms could be explained by the UTI but this would not account for the positive urine test. In addition both the EMT provider and the ER personnel noted that on presentation the patient had pin point pupils. Finally I could find no evidence that Narcan [naloxone] causes a positive opioid result on a urine test.

Rec: *1 - Attorney Work Product - RCW 42.56.290*

gh

CONFIDENTIAL INVESTIGATIVE REPORT

PREPARED FOR THE

MEDICAL QUALITY ASSURANCE COMMISSION

****

CASE #2011-153821MD

Respondent: Medical Unknown **Attorney:**
Business Address:
ILRS Address:
Board Certification/Type of Practice: Office Based Practice
Education:
DOB:
Licenses:

Complainant: Ron & Valerie Foulds, JR. **Attorney:** NA
712 Spruce St.
Hoquiam, WA 98550 (360-533-5767 phone)

ATTORNEY Address: NA

Investigative Case File completed by Investigator: Connie Pyles Date: 03/31/11

APPROVED: _____ DATE: 3-31-11

PRIOR CASE HISTORY:

Unknown

GENERAL CASE SUMMARY

COMPLAINT / ALLEGATIONS:

The complainants think that the 90 y/o father received a medication not prescribed for him which caused him to become unresponsive and hypotensive. He was treated at a local hospital where he reportedly tested positive for narcotics which are not part of his normal medication regimen.

CASE REVIEW:

On 03/16/11 the Complainant and his wife, Valerie Foulds were interviewed **(Pages 5-6).** They visit his father, 2 - Healthcare Information Readily Ide... ., at the Montesano Health and Rehabilitation Center (MHRC) at least 2-3 times per week. Mr. 2 - Healthcare I... has lived there for 4 years. He married a female resident in that time period. They are "very involved" in Mr. 2 - Healthcare Inf... care.

His father is described as mentally alert and wheelchair bound because of two leg amputations.

On 02/08/11 the Complainant had taken his father to the dining room between 12:00 and 1:00. A "nurse" described as 50-60 years of age with "shoulder length gray hair" came to his father with two cups of pills in applesauce in her hand. She'd said, "Mr. 2 - Healthca... , I have your new medication."

That nurse gave one cup to Mr. 2 - Healthcare Infor... and one to his wife. The Complainant does not know what was in the cup. He came home and asked his wife if anyone had called about a new medication and she said they hadn't. The facility was in the habit of "always informing" them if his father was to be prescribed any new meds, creams, etc. They'd heard nothing about a new medication.

The Complainant and his wife received a call from the hospital approximately 11PM that night. His father had been brought in by ambulance, unresponsive with dilated pupils. They were asked if his father was on any narcotics, and they said, "Absolutely not". Mr. 2 - Healthcare Inf... was on "numerous meds", but no narcotics.

They discovered the Montesano Fire Department had given Mr. 2 - Healthcare In... Narcan, to which " in 15 minutes he was responsive and talking". They had "met the ambulance at the hospital".

He was admitted that night at Gray's Harbor Community Hospital (GHCH) and discharged on 02/14/11 **(Pages)**. He tested positive for hydrocodone and a drug sample was also sent away for testing. Mr. 2 - Healthc... does not take hydrocodone and is not in the habit of taking other patients' medications at the rehab facility.

They kept a journal of the incident and agreed to send a copy of it along with the second page of their complaint **(Pages)**.

On 03/21/11 Kathy Stone, DNS for MHRC was interviewed **(Page 27).** She stated the NAC who gave Mr. 2 - Healthcare Info... his medication is Laurie Justice. She wears braces and has a bit of a speech impediment. She had been unable to give him his morning medication on 02/08/11 as he was still asleep. She found him in the lunchroom with his son. She has informed Mr. 2 - Healthcare Inf... that she was there with his "noon" medications, not "new" medications.

Ms. Stone had specifically asked her about this. Ms. Justice is willing to provide a statement to that effect. That statement is found on **Page 28**, which reiterates the aforementioned information on Mr. 2 - Health... "noon" medications.

Ms. Stone informed me that Mr. 2 - Healthcare Inf... had been given Narcan by the medics on 02/08/11 when he was found unresponsive and at the ER. No urine sample had been collected prior to the administration of that medication. Narcan can bring about false positive results. She also noted that Mr. 2 - Health... had been tested positive for marijuana at that hospital admission. This has caused her to question whether the hospital's lab test is accurate.

Mr. 2 - Healthcare Inf... is not prescribed any narcotics. Neither is his wife, Hilda, who had been given medication at the same time as her husband. She stated their narcotics log book had been reconciled for that day. She cannot think of a way that Mr. 2 - Healthcare In... could have gotten hold of any opiates. She had explained this to the Complainant.

Mr. 2 - Healthcare In... is still at their facility and is back to his baseline status.

Mr. 2 - Healthcare Infor... "Incident/Accident Report" is found on **Pages 30-33).** It reads, "Narcan administered will result in False +. Resident was septic upon admission and returned with diagnosis of MRSA in urine, which would have been indicative of decreased LOC. Although conclusion cannot positively state Oxycodone was or wasn't administered It is more than likely + was from Narcan 2) decreased LOC was from sepsis."

The MHRC records are found on **Pages 34-101.**

The Gray's Harbor Community Hospital (GHCH) records are found on **Pages 102-135.** The ED report reads, "He responded to Narcan initially and now has decreasing mental status." At the ED "the patient was started on a Narcan drip."

The assessment/plan reads, "Acute respiratory failure, obtunded encephalopathic, unable to protect airway. This could possibly be secondary to oxycodone toxicity. This, however, was not prescribed and it is unclear exactly how the patient could have received this. A repeat toxicology screen, however, was positive. It certainly could be a real ingestion. It could be a false positive. His condition could also be sepsis secondary to urinary tract infection or possibly pneumonia. Sepsis can occasionally improve with Narcan as well temporarily and his episode was also complicated by hypotension." He was admitted.

The Toxicology report is found on **Pages 129-130.** There are abnormal results on 02/12/11 for benzodiazepines, THC (Marijuana) and Oxycodone. A toxicology report from 02/09/11 indicates negative results for THC **(Page 62).**

The urine culture was positive for Staphylococcus Aureus **(Page 131).** The MRSA screen was negative, as well as the blood culture **(Pages 133-134).**

The hospitalist report reads, "Altered mental status, likely secondary to urinary tract infection." **(Pages 80-82)**

This investigation is completed and the case file forwarded to Program for review.

CONTACTS:

Complainant

Montesano Health and Rehabilitation Center
Kathy Stone, DNS
800 N. Medcalf
Montesano, WA 98550
360-249-2273 phone
360-249-2363 fax

Connie Pyles, Investigator
Medical Quality Assurance Commission
Department of Health
PO Box 47866
Olympia, WA 98504-7866
(360) 236-2776
FAX (360) 586-4573

ACTIVITY:

Date	Activity
03/03/11	Received case file, review complaint, open case file, enter into Monthly Report for tracking purposes, begin activity log.
03/09/11	Case review.
03/15/11	Interviewed Complainants and composed memo.
03/16/11	Completed memo to file. Faxed record request to Gray's Harbor, Montesano Health & Rehab Ctr. Called Kathy Stone, DNS, left message for her to call me.
03/17/11	Received VM from Ms. Stone. Received additional documentation from Complainants.
03/21/11	Called Kathy Stone. Received and reviewed Gray's Harbor records.
03/31/11	Received MHRC records. Compose investigative report.

MQAC ASSIGNMENT MEMO

Case #: 2011-153821

Respondent: Medical Unknown

Date Received: 2-23-11 Date Assigned: 2-23-11

Investigator: Connie Ryles

Priority: A____ B____ C X D____ Code: 01

____ Respondent Notification Letter

✓ Complainant Acknowledgement Letter

✓ Whistleblower Letter & Waiver

____ Malpractice Letter

Abandonment	Health & Safety Violations	Neglect	Possible Summary Action	Sexual Misconduct
Abduction	High visibility	No Patient Harm	Practice Beyond Scope	Single Complaint Process
Abuse	Imminent Harm	Non-Compliance	Prohibition in another state	Standard of Care
Action w/other state/jurisdiction	Inappropriate Communication	Other	Sanitation	Substance Abuse
Credential Application	Inspection Issues	Patient Abuse	Serious Injury	Testing Issues
EMTALA	Jurisdictional Questions	Patient Death	Serious Physical Harm	Transfusion Fatality
Exposure to physical/fire hazards	Mandatory Suspension	Physical Plant	Sexual Contact	Unlicensed Practice

Comments: Records

MQAC REVIEW
Case Number: 2011-153821

Date: February 14, 2011
Presented by: **George Heye, MD**

Respondent:	**MEDICAL, UNKNOWN**	**Grays Harbor County**

Complainant:	**Ron and Valerie Foulds, Jr.**

CASE SUMMARY

The Respondent:

Board Certified:	Unknown
DOB:	Unknown
Licensed since:	Unknown
Expiration date:	Unknown
Medical School:	Unknown
Residency:	Unknown

The Complainant: The son and daughter-in-law of a patient

Malpractice Settlement: N/A.

The Complaint: The complainants think that the 90 y/o father received a medication not prescribed for him which caused him to become unresponsive and hypotensive. He was treated at a local hospital where he reportedly tested positive for narcotics which are not part of his normal medication regimen.

RCM Review

Prior Cases:

Unknown.

Recommendation:

MEDICAL QUALITY ASSURANCE COMMISSION

CMT

Review of Cases

CMT DATE/
Panel Members/
Decision:

MQAC CMT - FEBRUARY 23, 2011
Rick Dore, Chair, MD
Susan Harvey, MD
Judy Tobin, Public Member
Terri Elders, Public Member
DECISION: ***Investigation authorized***

Case No.: 2011-153821

The attached pages were reviewed:

47-49

MQAC REVIEW
Case Number: 2011-153821

Date: February 14, 2011
Presented by: **George Heye, MD**

Respondent:	**MEDICAL, UNKNOWN**	**Grays Harbor County**

Complainant:	**Ron and Valerie Foulds, Jr.**

CASE SUMMARY

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DOB:	Unknown
Licensed since:	Unknown
Expiration date:	Unknown
Medical School:	Unknown
Residency:	Unknown

The Complainant: The son and daughter-in-law of a patient

Malpractice Settlement: N/A.

The Complaint: The complainants think that the 90 y/o father received a medication not prescribed for him which caused him to become unresponsive and hypotensive. He was treated at a local hospital where he reportedly tested positive for narcotics which are not part of his normal medication regimen.

RCM Review

Prior Cases:

Unknown.

Recommendation:

Washington State Department of Health
Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98504-7866
Phone: 360.236.2762 Fax: 360.586.4573
E-mail: medical.commission@doh.wa.gov

RECEIVED
FEB 14 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Complaint Form

Today's Date: 2-11-11

1. Your Information

Name: Ron / Valerie Foulds Jr.

Address: 712 Spruce St.

City: Hoquiam State: Wa Zip: 98550

Phone: Home: (360) 533-5769 Work: (___) ___-_____

Cell Phone: (360) 581-7676 E-mail: rvfoulds@msn.com

2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: _____

Clinic or Facility: Montesano Health and Rehabilitation Center

Address: 800 N. Medcalf

City: Montesano State: Wa Zip: 98550

3. Patient Information

Full name: 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW ...

Date of Birth: 2 - Healthcare Information R...

Date of incident: 2/8-2/9 2011

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

5. Reports involving fee for fee disputes or insurance claims are only investigated if there appears to be fraud involved.

6. Please describe your complaint in the space below. Include the names, title and phone number of any witnesses that were involved in the complaint.

7. Please attach any supporting documentation or additional information you may have.

You may submit a complaint to the Medical Commission by mail, fax or email at:

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98504-7866
Fax: .360.586.4573

Please describe your complaint in the space below. Include names, titles and phone numbers of any witnesses. Please attach copies of documents to support your complaint. You may mail, email or fax this form to the Medical Quality Assurance Commission at the physical address, email address, or fax number above.

My father may have been given a medication that was not prescribed to him at the facility which caused him to be taken to the hospital on the night of 2/8. He was unresponsive when he arrived and his blood pressure started dropping. He was tested for narcotics which was positive. He is on no narcotics of any kind. He was given a drug called Narcam? which is for overdoses and was concious for only a few minutes. He was given this numerous times. He had to be resuscitated because his blood pressure had dropped to the extent that he was dead. He was

Please include additional sheets as necessary.

Case View Screen [update]

Case	2011-153821 (PUBLIC)	Date Created	02/14/2011	**Audit**
Status	Investigation	Date Received	02/14/2011	Entry Items
		How Received	Mail	Documents
Respondent ID	232147	Receiving Board	COMMISSION	Notes
Respondent	UNKNOWN MEDICAL	Receiving Profession	Physician And Surgeon License	Master Cas
		Receiving Department	Case Intake	Participan
Complainant ID	982094	Received By	Cynthia R Hamilton	Add Maste
Complainant	Ron and Valerie Foulds Jr	**Alleged Issues**		Timeline H
		Error in Prescribing, Dispensing or Administering Medication		
		Patient Care		
		Case Nature		
		Standard of Care/Services		

Comments:

- **Priority History**
- **Other Participants**
- **Resolution**
- **HIPDB Reports**
- **TimeTracker**
- **Action Items**

Priority History [add]

Date	Priority	Priority Reason	Decision Maker	Decision Date	Comment	COR	User
Mar 3 2011 10:00AM	C Priority	**Standard of Car...**	Medical Commission	02/23/2011		NO	Creighton, Vi

Other Participants [add]

No additional participants found

Resolution [update]

Department: Investigation	**Found Issues**
Worker: Connie Pyles	none
Date Closed:	**Resolution**
	none

Resolution Notes:

Current HIPDB Reports

Type	Submission Date	Status	DCN	Case I
No HIPDB Reports found for this credential.				

Time Tracker

Charge_Back_Totals

Department	Hours	Amount

Cost_Recovery_Totals

Department	Hours	Amount

Cost_Recovery_Invoicing

Respondent	InvoiceDate	User

Action Items [add] [add group]

Type	Assigned To	Activity	Track Time	Due	Effective	Completed	Order Signed	Created ▼
Assign Investigator	Investigation, Pyles, Connie		[add]		02/24/2011	02/24/2011		03/03/2011
Target: UNKNOWN MEDICAL								
Action Info: Priority Set and Entered? Yes								
Investigative - General	Investigation, Creighton, Vicki1		[add]		02/24/2011	02/24/2011		02/24/2011
Target: UNKNOWN MEDICAL								
Comments: 2-25-2011 Acknowledgement & whistleblower waiver letters mailed								
Forward for Investigation	Investigation Supervisor, Smith, James H				02/23/2011	02/23/2011		02/24/2011
Target: UNKNOWN MEDICAL								
Case Status: Status Changed To: Investigation								
Present for	Case Management, Creighton, Vicki1				02/14/2011	02/23/2011		02/24/2011

Assessment

	Target:	UNKNOWN MEDICAL			
	Case Status:	Status Changed To:	Assessment		
	Action Info:	Decision Date	02/23/2011		
		CMT Decision Maker 1	Dore Frederick		
		CMT Decision Maker 2	Harvey Susan		
		CMT Decision Maker 3	Tobin Judy		
		CMT Decision Maker 4	Elders Theresa		
		CMT Decision Maker 5	McLaughlin Jim		
		CMT Decision Maker 6	Heye George		
		CMT Decision Maker 7	Smith Jim		
		CMT Decision Maker 8	Newman Dani		
Present for Assessment	Case Management, Hamilton, Cynthia R			02/14/2011	02/23/2011	02/14/2011
	Target:	UNKNOWN MEDICAL			
	Case Status:	Status Changed To:	Assessment		
Intake	Case Intake, Hamilton, Cynthia R			02/14/2011	02/14/2011	02/14/2011
	Target:	UNKNOWN MEDICAL			
	Warning:	Warning Type:	CASE PENDING		
		Warning Effective Date:	02/14/2011		
		Suppress License Print:	NO		
	Case Status:	Status Changed To:	intake		
	Action Info:	Complaint Source	Family Member		
		Possible Imminent Danger?	No		
		Single Complaint Process Coordination Needed?	No		

Contact View Screen [update]

UNKNOWN MEDICAL

Address: (•) Public ( ) Mail

UNKNOWN MEDICAL
No ASI Address

ID	839142
Warnings	
SSN/FEIN	
Contact Standing	Living
Contact Type	ENFORCEMENT ENTRY
Public File	YES
Mailing List	

Audit
Public Cases
Cont. Edu
Documents
Owned By/Key Mgmt
Exams
Experience
Notes
Schools
Supervises
SupervisedBy
Legacy
Librarian
Application
Other State License

Comments:

Addresses | Personal Information | Legacy

Contact Addresses [add]

UNKNOWN MEDICAL No ASI Address Joined on: 2/16/2008 6:19:15 PM Last updated by LEGACYDATA	Phone Fax Cell Email	[update] MAIN ADDRESS Public Address Mail Address Form Letter

2011-153821

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

April 28, 2011

Ron & Valerie Foulds, Jr.
712 Spruce St
Hoquim, WA 98550

Subject: Your Case Against an Unknown Medical Doctor
Re: Case # 2010-153821

Dear Mr. and Mrs. Foulds, Jr.:

The Medical Quality Assurance Commission has completed its investigation of your complaint concerning an unknown medical doctor. The Commission is committed to protecting the health and safety of citizens of the state of Washington. The Commission takes every complaint seriously.

To take disciplinary action against a physician's license, the Commission is required to prove by clear and convincing evidence, a high burden of proof, that the medical treatment provided posed a risk to the public. After careful review of the information gathered during the investigation, the Commission determined that the risk to the public is minimal and not likely to reoccur. Based on this review, the Commission closed the case.

Thank you for bringing your concerns to the attention of the Medical Quality Assurance Commission.

Sincerely,

Mike Krauss
For

Dani Newman, Disciplinary Manager
Medical Quality Assurance Commission

EVIDENCE / ATTACHMENTS:

Page	Description
1	WAC 246-15-030 notice
2-4	Complaint
5-6	Memo to File regarding interview with Complainants
7-26	Additional documentation from Complainant
I27	Interview with Kathy Stone, DNS
28	Statement from Laurie Justice
29-33	Incident/Accident report from Ms. Stone
34-101	Medical records received from MHRC
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SUPPORTING DOCUMENTATION:

136-140	Correspondence to and from Complainant
141-153	Medical record requests to MHRC and GHCH

NOTICE

WAC 246-15-030, procedures for filing, investigation, and resolution of whistleblower complaints.

(1)(b) Instructs that staff will affix a permanent cover to the letter of complaint or other form of notice in the complaint file, noting the statutory citation concerning protecting the identity of the complainant.

(3)(c) Ensure upon case closure, that the permanent cover affixed in subsection (1)(c) of this section will remain.

RCW 43.70 provides that the identity of a whistleblower who complains in good faith to the Department of health about the improper quality of care by a health care provider as defined in RCW 43.72.010 ***shall remain confidential***.

Pursuant to the above RCW and WAC it is staff's duty to see that the complainant's name or any information which may identify the complainant is not disclosed.

NOTICE

Washington State Department of Health
Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98504-7866
Phone: 360.236.2762 Fax: 360.586.4573
E-mail: medical.commission@doh.wa.gov

Complaint Form

Today's Date: 2-11-11

1. Your Information

Name: Ron / Valerie Foulds Jr.

Address: 712 Spruce St.

City: Hoquiam State: Wa Zip: 98550

Phone: Home: (360) 533-5767 Work: (___) ___-_____

Cell Phone: (360) 581-7676 E-mail: rvfoulds@msn.com

2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: _____

Clinic or Facility: Montesano Health and Rehabilitation Center

Address: 800 N. Medcalf

City: Montesano State: Wa Zip: 98550

3. Patient Information

Full name: 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), R...

Date of Birth: 2 - Healthcare Information Re...

Date of incident: 2/8-2/9 2011

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

5. Reports involving fee for fee disputes or insurance claims are only investigated if there appears to be fraud involved.

6. Please describe your complaint in the space below. Include the names, title and phone number of any witnesses that were involved in the complaint.

7. Please attach any supporting documentation or additional information you may have.

You may submit a complaint to the Medical Commission by mail, fax or email at:

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98504-7866
Fax: .360.586.4573

Please describe your complaint in the space below. Include names, titles and phone numbers of any witnesses. Please attach copies of documents to support your complaint. You may mail, email or fax this form to the Medical Quality Assurance Commission at the physical address, email address, or fax number above.

My father may have been given a medication that was not prescribed to him at the facility which caused him to be taken to the hospital on the night of 2/8. He was unresponsive when he arrived and his blood pressure started dropping. He was tested for narcotics which was positive. He is on no narcotics of any kind. He was given a drug called Narcam? which is for overdoses and was concoious for only a few minutes. He was given this numerous times. He had to be resuscitated because his blood pressure had dropped to the extent that he was dead. He was

Please include additional sheets as necessary.

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

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revived and then ~~[illegible]~~ we were asked if we would ok a breathing tube. He has a DNR. order but we were told this would bring up his pressure. The doctor told us she would give him more of the (Narcan?) to revive him enough to ask him if that was ok. which she did and he would let them do it. He was stable after the tube was inserted. He also had a UTI. There are other things that also happened that are in his medical records at Grays Harbor Community Hospital. He was taken to CCU were he has been.

We would like this incident investigated He has been at Montesano Rehab for 4 years. We see him 2 to 3 times a week and are very involved in his life. He ~~[illegible]~~ was fine when I was there on the afternoon of this incident.

Please include additional sheets as necessary.

DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS

MEMORANDUM TO FILE

DATE: 03/16/11

TIME: 08:10 AM

CASE #: 2011-153821MD

RE: Interview with Complainant and his wife Valerie

FROM: Connie Pyles, Health Care Investigator

The Complainant and his wife, Valerie Foulds, visit his father, 2 - Healthcare Information Read... Sr., at the Montesano Health and Rehabilitation Center at least 2-3 times per week. Mr. 2 - Healthcare In... has lived there for 4 years. He married a female resident in that time period. They are "very involved" in Mr. 2 - Healthcare Infor... care.

His father is described as mentally alert and wheelchair bound because of two leg amputations.

On 02/08/11 the Complainant had taken his father to the dining room between 12:00 and 1:00. A "nurse" described as 50-60 years of age with "shoulder length gray hair" came to his father with two cups of pills in applesauce in her hand. She'd said, "Mr. 2 - Healthc..., I have your new medication."

That nurse gave one cup to Mr. 2 - Healthcare Infor... and one to his wife. The Complainant does not know what was in the cup. He came home and asked his wife if anyone had called about a new medication and she said they hadn't. The facility was in the habit of "always informing" them if his father was to be prescribed any new meds, creams, etc. They'd heard nothing about a new medication.

The Complainant and his wife received a call from the hospital approximately 11PM that night. His father had been brought in by ambulance, unresponsive with dilated pupils. They were asked if his father was on any narcotics, and they said, "Absolutely not". Mr. 2 - Healthcare Inf... was on "numerous meds", but no narcotics.

They discovered the Montesano Fire Department had given Mr. 2 - Healthcare Inf... Narcan, to which " in 15 minutes he was responsive and talking". They had "met the ambulance at the hospital". The rehab facility did not send staff with their patient.

He was admitted that night at Gray's Harbor Community Hospital (GHCH) and discharged on 02/14/11. Four days were spent in the ICU. He tested positive for hydrocodone and a drug sample was also sent away for testing. Mr. 2 - Health... does not take hydrocodone and is not in the habit of taking other patients' medications at the rehab facility.

Mr. 2 - Healthc... has a "DNR" plan, but they were asked if a breathing tube was okay, which they agreed to.

There was a DSHS facilities investigation and the Complainant and his wife were informed that "all the medication was accounted for".

They received hospital records and noted a Dr. Givens had written Mr. 2 - Health... had been intubated in the past when he was treated for a UTI, which they said was not true.

They kept a journal of the incident and agreed to send a copy of it along with the second page of their complaint. The interview was then concluded.

~~Wallace VA~~

Dr. Buck - ER Dr.
2/8/11

Tuesday - When [redacted] was at MR at lunch time a nurse came in and told [redacted] and he that she had a "new medicine" for him.

Tuesday 1:20 - Charles called and said Dad was "unresponsive." He wanted to know if Dad should be sent to the hospital. Then I also was on the line and said yes. Charles did not make it very clear what unresponsive ~~was~~ meant.

When we got to the hospital he had arrived. ~~He~~ We waited for him to arrive. When we went to the back he told us he felt runny. He didn't have his teeth. Hard to understand.

Doctor told us he had narcotics/opium tested positive.

Dr. was going to give him Narcan to bring him around. When she did he came around for a few minutes then he would go to sleep again. ~~He was always sleep~~

Dr. Buck told us that's what they do for someone on drugs.

He rested comfortably for awhile then his blood pressure dropped way down and the medical staff started to revive him. He was almost gone. If they hadn't revived him.

Machine beeping over 20 mins

Told he needed to be tubed to get his blood pressure up. We said it was hard decision because he didn't want extra measures. Dr. said she would give him Narcan to wake him up and ask him. She did it twice 1st time No!! Second time she told him it would get his blood pressure up. He said yes!

Dr. Owens
Didn't see until 6:00 2/9/11

He was tubed. Did much better
Pressure up.
Had Cat Scan - No Stroke
X Rays of chest. - No pneumonia

2/9/10 Social Services - Talked to a gentleman. Asked if Dad was going back? Don't Know yet? 1:00 pm

5:30 moved to CCU to be ~~[illegible]~~ Closed monitered.
Sally Root - Nurse. - Great

2/9/11 On monitors all day Monitered very Closly

James. Nurse - Great

Weds 2/9/11

CCU all day

He was tubed

* Rested comfortably

* James took wonderful care.

About 6:30 we talked to

* Dr. Givens and she said that the tube could be removed so we authorized for it to be removed but she wanted to know if his pressure dropped would we put it back in. She said it would be best to do. [redacted] said ok as long as it would be for something fixable.

We left about 7:30 - 8:00

Turned every 45 mins to 1 hr.

Didn't see any Dr. until that night.

Dad's mental state was alert when the tube was removed. He knew us all but he was extremely tired.

We left about 1½ hrs. after the tube was removed. He was resting comfortably

Thursday 2/10/11

When we got there around 12:00 we were told that we had to gown up because he had MRSA. (weird)

* He was also started on breathing treatments when the Lady came in to give him the treatment James (his nurse) questioned why he was getting one that his chest sounded clear. The Lady was very short with him and told him that all she does is follow orders. And the orders came from Dr. Evans He was given this treatment every 4 hrs. through the night.

He was also given antibiotics for the MRSA.

His mental state was very good. Was bright and alert. Knew where he was and who we all were.

Friday 2/11/11 We arrived 12:15

Called about 10:30 am and he was a little confused on the phone. Asking about work just not himself like he was yesterday. Very groggy kept asking about work when was he leaving. Nurse Come in and took his blood for diabetics and she said it was high and started to talk to us about diabetics that when he returned that he would probably need to have a diabetic diet, got upset saying he has never been diabetic. He was given an insulin shot. He also had numerous breathing →

She also said that she was septic with the infections.

Dr. Givens finally come back around 6:30 and the first thing she said was if we went to court [redacted] with him having other infections we probably wouldn't have a leg to stand on. We were very uncomfortable for her to say that right off. She told us that his X-rays showed pneumonia and that he also had a UTI when he come in. She said We may never know what happened to him. Waiting on test from Quest but still we would not find out exactly what happened. We talked about moving him ~~but~~ to a different Rest home →

[redacted]

treatments.
Also today we had a paper put on his chart that he is not sign or talk to anyone without us there.
Nurse Pauline Stamon put it on his chart.
CCU

but we wouldn't because of Hilda. She also said she would never cover for anyone else. definitely not for a rest home. She also wanted to know if we wanted a feeding tube if he was not eating. We said no because he doesn't eat as much anyway.

Saturday 2/12/11

Moved from ICU to Rm. 315 at 2:00pm.
When we got to the hospital he was
extremely tired. did say some things that
didn't make sense.
Still in quarentine / No IVs just
still having antibotics

At 4:45 102/56 blood pressure
Ate dinner Soup / ½ Sandwich coffee.
Had Eggs for breakfast
Brought up PDA for chart.

Nurse Pm - Desiree
CNA - Lisa

Has rash on his upper body given Benedryl

Talked to Hilda

/

Sunday 2/13/11 BP: 126/60
We got there 2:30 pm. Blood Sugar 125
5:00
Dad was confused. Told us he
was looking for his shoes. He had
to go to get his hamburger.
Also told us there were rockets shooting
off on the hill across from the hospital.
He was talking about things that didn't
make any sense. He was wide awake
but talking nonsense. He knew who we
were and could tell the nurse his
name. He saw birds land outside the
window.

Rash on his body looks better.
No IVs
Did not see Dr.
Left at 7:30 pm

Monday 2/14/11

Went home to Monte at 2:00
Had to take the transit back
to Monte.
Had rash on his private area
Nursing supervisor came in and
told us that all meds were accounted
for. She also told us that the
narcan could have caused the false/pos
on the drug test.
We said that we assumed the drug
test was done before he got any Narcan
Rebecca also told us she saw him
before bed and he seemed fine.
Hilda was in bed when we got to Monte.
Dad napped and then we waited in the
dining room for them to get him
dressed. Again 1 person at first in dining room
They both come down for dinner. He
ate about 1/3 of his meal. Seemed
tired. Rebecca gave him Benedryl for
all of the rashes on his body.

Called the Complaint Hotline 8:00 2/14/11

Tue
Friday 25th

We stopped and talked to Cory Rux that is a paramedic. He was not the paramedic that took Dad to the hospital. Ron asked him why his father was given Narcan and he said they usually don't give it to patients unless they show ~~seizure~~ symptons of a drug. Dad had these symptons by what the report was that he looked at. So they administered the Narcan which he showed improvement within 15 mins.

Mr. Rux also told us that as a regular citizen he would follow through. He has never heard of Narcan showing a false positive. I told him that we are having an investigation done that Dr. Buck the ER. DR told us also to fill out papers to start an investigation. He also told us that we could get the records if we need them.

TRANSACTION DATE	DOCUMENT NO. PRESCRIPTION NO.	QUANTITY	DAYS	DESCRIPTION	CREDITS	CHARGES
						0.00
01/03/11	RF6162792	30	30	CITALOPRAM 20MG TAB (SSRI) 13107-0006-05 DR.BUBEN DO	COPAY	1.00
01/06/11	RF6235720	30	30	ROPINIROLE HCL 1MG TAB (Parkinson) 68382-0340-01 DR.BUBEN DO	COPAY	1.00
01/06/11	RX6474226	30	30	MIRTAZAPINE 15MG TAB anti-depressant 13107-0031-34 DR.BUBEN DO	COPAY	1.00
01/12/11	RF6132554	30	30	POTASSIUM CL 10MEQ(KLORCON)TAB 00245-0041-15 DR.BUBEN DO	COPAY	1.00
01/12/11	RF6132570	120	30	OMEPRAZOLE DR 20MG CAP stomach acid 62175-0118-43 DR.BUBEN DO	COPAY	1.00

MAR

TRANSACTIONS THROUGH 01/15/11
*** THANK YOU FOR USING PAYLESS PHARMACY ***

Previous Balance	Charges	Finance Charge	Total	Credits	AMOUNT DUE
0.00	5.00	.00	5.00	.00	5.00

30 Days Past Due	60 Days Past Due	90 Days Past Due
**	**	**

MD 2011-153821-000018

Account #: 77041

2 - Healthcare Information Readily Identifiable to a Person...

FINANCE CHARGES are calculated at a **MONTHLY PERIODIC RATE OF 1.5% (ANNUAL RATE OF 18%)** based upon an unpaid balance of outstanding 30 days or more as of billing date:01/15/11

MINIMUM FINANCE CHARGE $3.00

Payless Drug
Long Term Care Pharmacy
PO Box 230969, Portland, OR 97281-0969
503-626-9436
800-330-3665

X1101810 00019401010000

N,N,N,N,N

IDENTIFICATION
This 90-year-old male presente from Montesano Health and Rehabilitation Center because of the sudden onset of change in mental status. He responded some to Narcan initially and now has decreasing mental status. He was intubated in the emergency department.

HISTORY OF PRESENT ILLNESS
He was in his usual state of fair health, living at Montesano Health and Rehabilitation Center with his wife. His son reports that he saw the patient at lunch and he was in his usual state of health. Then, reportedly, he was found to be obtunded with shallow respirations. He had only moaning. He did wake up for the paramedics briefly after Narcan. At that time, he was transferred to the emergency department.

There, his paperwork showed he was DNR and they contacted the family. The patient was started on a Narcan drip. Because of intubation, he was given empiric ceftriaxone, 1 gram IV, normal saline boluses, and Zosyn 3.375 mg.

It was decided that the patient required intubation due to increasing difficulty protecting his airway. He had hypotension, responding to IV fluids. Upon talking with the family, he told his family that he wanted intubation if it was thought to be reversible, and the decision was made to pursue intubation.

After intubation, part of the workup included a toxicology screen, which was positive for oxycodone. The nursing home was contacted again and there was reportedly no prescribed oxycodone and no obvious thought how the patient could receive oxycodone.

His blood sugar at the time was 253. His family said this was a sudden change in his mental status. He has required intubation at times in the past and has had episodes of urinary tract infections, thought to be secondary to methicillin-resistant Staphylococcus aureus. He has had significant peripheral vascular disease and has been on chronic medications. He has had no fevers, chills, or other complaints.

This is not true except with his amputations unless with a UTI.

ALLERGIES
1. BACTRIM.
2. CLINDAMYCIN.

PAST MEDICAL HISTORY
1. Peripheral vascular disease, status post amputation bilaterally above the knee.
2. Hypertension.
3. GERD.
4. Peptic ulcer disease.
5. Hyperlipidemia.
6. BPH.

7. Iron-deficiency anemia.
8. History of GI bleed in 2008.
9. Depression.
10. Chronic atrial fibrillation.

MEDICATIONS
1. Remeron 15 mg p.o. q.h.s.
2. Citalopram 20 mg p.o. daily.
3. Norvasc 5 mg daily.
4. Diovan 80 mg daily.
5. Finasteride 8 mg p.o. daily.
6. Vitamin C 500 mg daily.
7. Multivitamin 1 daily.
8. Iron sulfate 325 mg daily.
9. Flomax 0.4 mg p.o. daily.
10. Omeprazole 20 mg p.o. daily.
11. Carafate 1 gram p.o. b.i.d.
12. Requip 1 mg p.o. q.h.s.

SOCIAL HISTORY
He lives at Montesano Health and Rehabilitation Center. He has a wife. A son and daughter-in-law assist in his care. Nonsmoker. No history of alcohol intake. No recreational drug use.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 136/66, heart rate 64, respiratory rate 18, temperature 97.6, oxygen saturation 100% on the ventilator, 100% FiO2, tidal volume 500, PRVC 18, PEEP 5, pH 7.29, PCO2 28, PO2 207. Weight 54.5 kg.

NECK: No evidence of JVD.

LUNGS: Clear. Decreased in the bases.

HEART: Regular rate and rhythm.

ABDOMEN: Soft, nontender. No hepatosplenomegaly or masses.

EXTREMITIES: No clubbing, cyanosis or edema. As listed above, bilateral above-the-knee amputations.

NEUROLOGIC: Follows some commands. Moves extremities.

DIAGNOSTIC STUDIES
Pertinent lab work includes a sodium of 141, potassium 5.2, chloride 111, bicarbonate 23, BUN 40, creatinine 1.2, and glucose 291. White blood cell count 16.1, increased polys but no bandemia, hematocrit 41, MCV 95.9, platelets 230,000. Magnesium 2.2, bilirubin 0.1, ALT 15, AST 21, alkaline phosphatase 105. Troponin T less than 0.01.

Blood cultures x2 obtained. Sputum x2 obtained.

Urinalysis: 2+ leukocyte esterase, 1-5 white blood cells; culture pending.

Toxicology screen positive for oxycodone. A repeat was requested and that too was positive for oxycodone.

A head CT without contrast shows small-vessel disease.

Chest x-ray: No focal airspace disease. ET tube placement okay.

EKG: Atrial fibrillation at a rate of 102. Slow R wave progression. Nonspecific ST-T wave changes.

ASSESSMENT AND PLAN

1. Acute respiratory failure, obtunded, encephalopathic, unable to protect airway. This could possibly be secondary to oxycodone toxicity. This, however, was not prescribed and it is unclear exactly how the patient could have received this. A repeat toxicology screen, however, was positive. It certainly could be a real ingestion. It could be a false positive. His condition could also be sepsis secondary to urinary tract infection or possibly pneumonia. Sepsis can occasionally improve with Narcan as well temporarily and his episode was also complicated by hypotension. This could be systemic inflammatory response syndrome or sepsis. No obvious infiltrate. Clinically improved at this time. Long family discussion. We will attempt weaning parameters, hoping to extubate him and will follow sputum cultures carefully.

2. Pyuria. This could also be a urinary tract infection. The patient is on ceftriaxone. Follow cultures. IV hydration.

3. Systemic inflammatory response syndrome, present on admission, now with mild acute renal failure and dehydration. Aggressively hydrate.

4. Depression. Continue medications.

5. Candida of the skin, also suggested by sputum Gram's stain. Fluconazole and nystatin powder to skin folds. Multivitamin, zinc, vitamin C.

6. Gastroesophageal reflux. Continue Protonix.

7. Deep venous thrombosis prophylaxis. Lovenox subcutaneously 30 mg daily.

8. Hyperglycemia. Could be secondary to acute illness response. Check hemoglobin A1c. Sliding-scale insulin.

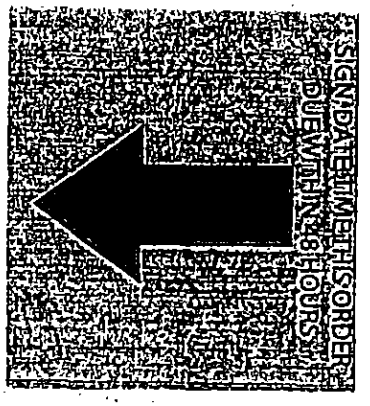
9. EKG showed atrial fibrillation, which is chronic. Rate controlled. Continue aspirin for cerebrovascular accident prophylaxis. Consider checking an echocardiogram.

10. Antihypertensives. Hold tonight in a setting of hypotension.

Barbara L. Givens, MD Date/Time

GIVBA/MEM D: 02/13/2011 at 19:02 T: 02/13/2011 at 19:19 J: 10644505 Doc: 20048393

CC: Michael Buben, DO



Quest Diagnostics Incorporated

PATIENT INFORMATION
2 - Healthcare Information Readil...

REPORT STATUS Final

QUEST DIAGNOSTICS INCORPORATED

DOB: 2 - Healthcare In... Age: 90
GENDER: M Fasting: U

ORDERING PHYSICIAN

CLIENT INFORMATION
98520700
GRAYS HARBOR COMMUNITY HOSP
915 ANDERSON DR
ABERDEEN, WA 98520-1006

SPECIMEN INFORMATION
SPECIMEN: OW4641865F
REQUISITION: 6757207
LAB REF NO: 2-9-11

COLLECTED: 02/09/2011 18:15
RECEIVED: 02/11/2011 03:50
REPORTED: 02/16/2011 16:35

COMMENTS: NONPHYS PROVIDER GIVENS

Test Name	In Range	Out of Range	Reference Range	Lab
OXICODONE SCREEN AND CONFIRMATION, URINE				AMD
OXYCODONE		POSITIVE		
OXYCODONE	2200		ng/mL	
COMMENT	SEE NOTE			

The submitted urine specimen was screened at the initial test level listed below. If positive, confirmatory testing was performed with the confirmation test level listed below. Confirmatory testing not performed on negative screens.

Analyte	Initial Test Level	Confirmation Test Level
Oxycodone	100 ng/mL	100 ng/mL

Performing Laboratory Information:

AMD Quest Diagnostics Nichols Institute-Chantilly VA 14225 Newbrook Dr Chantilly VA 20151
Laboratory Director: Kenneth Sieca M.D.

FOULDS,RONALD A - OW4641865F

Page 1 - End of Report

March 7, 2011

Valerie Foulds
712 Spruce Street
Hoquiam, Washington 98550-2218

RE: Control Number: 11-02-04370
Facility Name: Montesano Health & Rehab Center

Dear Ms. Foulds:

An investigator from RCS Region 6B has completed an unannounced investigation into the complaint referenced above. As you requested, a copy of the final investigation summary report is included with this letter.

As part of each on-site investigation, RCS obtains interview data from residents and families, facility staff, medical professionals and others; reviews the medical record; and conducts observations of residents and the facility environment. The focus of the RCS investigation is to determine if the facility/provider followed state and/or federal regulations regarding residents in their care. Failure to follow these regulations is considered failed facility practice or noncompliance. At this time, RCS did not identify failed facility practice (non-compliance) on the part of the provider named above.

You may contact the Field Manager Maureen Mead at (360) 725-2501 if you have any questions. Thank you again for sharing your concerns and for your assistance in helping to improve the quality of care for the vulnerable population in Washington State.

Sincerely,

G Van Vladricken

George Van Vladricken
Administrative Assistant
Residential Care Services

Enclosure

Residential Care Services
Investigation Summary Report

Control #: 11-02-04370 **License #:**1369 **Facility/Home:** Montesano Health & Rehab **Investigators:** Christine Kubiak **Region/Unit:** 6B
Licensee (AFH only): **Investigation Date(s):** 2/23/11
Complainant Contact Dates: 2/18/11, 2/28/11

Allegations:

1. Named Resident received overdose amount of Vicodin, which was not prescribed for the resident
2. Complainant had health and safety concerns for the resident's wife who is his roommate at the facility
3. Only one nursing assistant in the dining room assisting residents with their meals
4. Named Resident's adult briefs needed to be 70% soiled before it was changed

Investigation Methods:

☒ **Sample:** 2 Named Residents, 2 current residents
☒ **Observations:** 2 Named Residents, sampled residents, resident rooms/general environment, staff interactions with residents, care and services provided to residents during meals, availability of residents' incontinent briefs
☒ **interviews:** 2 Named Residents, 2 sampled residents, facility staff, nursing staff, others not associated with the facility
☒ **Record Reviews:** 2 Named Resident's record, 2 current residents' record, facility's accident/incident log and investigative reports, narcotic book

Investigation Summary:

1. Named Resident had an acute change in his level of consciousness and was sent to the Emergency Room (ER) for evaluation. The ER tested the named resident for drugs with a urine sample resulting in the urine being positive for oxycodone (pain narcotic) and notified the facility. The facility thoroughly investigated the distribution of their narcotics, checking all medication storage units, narcotic log books, residents' medication administration records and assessed the residents. No discrepancies or problems were found. The pharmacy verified medication accuracy of the named resident's used medication packets and the medications were accurate. The Named Resident's room was checked for medications and none were found. The facility thoroughly investigated the incident ruling out abuse and/or neglect with proper notification to the family, physician and State agency. Current residents or others not associated with the facility had no concerns with distribution of medications.

2. The Named Resident's wife was clean, well groomed and happy (smiling). The staff interacted with her in a helpful, caring and patient manner. She showed no signs of fear when staff approached her. The Named Resident's wife's record revealed the facility's interdisciplinary staff documented completely, appropriately and timely regarding the care and services provided to her. The sampled residents interacted with staff in a receptive manner without signs of fear. Staff were observed to be helpful, caring and patient with sampled and other residents. Current residents and others not associated with the facility were content with the care and services provided and voiced no safety concerns.

3. During the lunch meal, the facility's main dining room had a minimum of four staff and the three dining rooms on the halls had a minimum of two staff. The staff in the dining rooms assisted residents as needed with their meals in a timely manner. All residents received the level of assistance each required. Staff in the facility stated staffing was okay and could always be better. The Nursing Assistants (NA) said when staff call in sick, injure themselves, change jobs, go on vacation or extended sick leave, then more teamwork was required and overtime was always available. The NAs indicated the licensed nurses also pitched in and assisted with answering call lights, turning, and personal care. Sampled residents and others not associated with the facility indicated staff were available, helpful and very busy. No concerns of insufficient staff were voiced. There were no negative resident outcomes identified resulting from the residents not receiving proper care. This included but not limited to accidents, safety, skin breakdown, and cleanliness of residents/environment.

4. NAs said there were plenty of resident care supplies available within the facility to include incontinent pads. The NAs stated they checked and changed a resident at a minimum of every two hours and more often if needed. The NAs had not been told or heard of ensuring the brief was soiled a certain percentage before changing it. The Supply Coordinator (SC) stated there were no issues with ordering, purchasing and/or receiving resident [redacted] supplies. The SC explained the resident care supply room was accessible 24 hours a days, 7 days a week with a key maintained by one of the licensed nurses. The SC stated he was also available during his off duty hours to come in for anything needed. Sampled and random residents and others not associated with the facility indicated there were enough resident care supplies to include peri wash, incontinent pads, towels and linens. Sampled and random residents were well groomed, clean and without odor. No concerns of insufficient supplies or inadequate toileting/changing of incontinent briefs were voiced.

Conclusion:
☐ **Failed Practice Identified** ☒ **Failed Practice Not Identified**

Action:
☒ **No citation**
☐ **Citation(s) Written:**

Alleged Violation(s):

10-31-08 Template

DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS

MEMORANDUM TO FILE

DATE: 03/21/11

TIME: 01:24 PM

CASE #: 2011-153821MD

RE: Interview with Kathy Stone, DNS

FROM: Connie Pyles, Health Care Investigator

I spoke with Kathy Stone, DNS today. She is familiar with the issues brought forth by the Complainant. She stated the NAC who gave Mr. 2 - Healthcare Inf... his medication is Laurie Justice. She wears braces and has a bit of a speech impediment. She had been unable to give him his morning medication on 02/08/11 as he was still asleep. She found him in the lunchroom with his son. She has informed Mr. Foulds, Sr. that she was there with his "noon" medications, not "new" medications. Ms. Stone had specifically asked her about this. Ms. Justice is willing to provide a statement to that effect. A statement form, along with a medical record request, will be faxed to Ms. Stone.

Ms. Stone informed me that Mr. 2 - Healthcare Inf... had been given Narcan by the medics on 02/08/11 when he was found unresponsive and at the ER. No urine sample had been collected prior to the administration of that medication. It can bring about false positive results. She also noted that Mr. 2 - Healthc... had been tested positive for marijuana at that hospital admission. This has caused her to question whether the hospital's lab test is accurate.

Mr. 2 - Healthcare Inf... is not prescribed any narcotics. Neither is his wife, Hilda, who had been given medication at the same time as her husband. She stated their narcotics log book had been reconciled for that day. She cannot think of a way that Mr. 2 - Healthcare Inf... could have gotten hold of any opiates. She has explained this to the Complainant.

Mr. 2 - Healthcare Info... is still at their facility and is back to his baseline status. I informed her I'd be sending a record request and she indicated she'd include a copy of her findings of the incident. The interview was then concluded.

MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
STATEMENT FORM

File Number: 2011-153821MD

Statement of: LAURIE JUSTICE

Location where statement is taken: Montesano Health & Rehab

Statement: I approached Mr. 2 - Healthcare I... in the dining room where he was sitting at a table with his wife and son at approximately 11:50. I had medications for ~~to~~ Mr Foulds. And I said "Here are your noon meds." The pill I gave him (carafate) is scheduled for 1000, but I was giving it just before lunch because both Mr & Mrs 2 - Healthcare I... were sleeping at 1000. They had just gotten up to go to the dining room.

Mrs. 2 - Healthcare Inf... also recieves medications at noon so rather than disturbe them both, I decided to give Mr. 2 - Healthcar... his carafate at the same time as his wife takes her medications.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed: Laura J Justice **Date:** 26 Mar 11

Name: Laura J Justice **Time:** 1250

Address: PO Box 65 **City, Zip:** Hoquiam WA 98550

Telephone: (360) 532-1700 **Witness:** _____

Page _____ of _____

V/

Incident/Accident Report Checklist:

Resident Name: _____ **Date:** 020811

Initial Each Area

_____ Resident Assessment
_____ Resident made comfortable/immediate first aid
_____ Physician notified _____ phoned/faxed
_____ Family notified
_____ Resident sent to the hospital with:
- _____ Transfer sheet completed
- _____ Face sheet
- _____ Physician orders
- _____ Copies of H & P (if needed)
- _____ Copies of MAR
- _____ Advanced Directives/DNR

_____ Statement from resident interview (or interview roommate if resident is not interviewable.) (Document if resident is unable to be interviewed)
_____ Statements from all staff completed before they leave the facility
_____ Environmental check completed
_____ Skin assessment completed/skin condition sheet initiated (if indicated)
_____ Neuro sheet initiated (if indicated)
_____ Pain assessment completed on all incidents
_____ Fall assessment completed
_____ Braden scale completed
_____ Temporary care plan completed:
- _____ Copy attached to I/A report
- _____ Original in chart

_____ Physician orders in MAR/TAR and copy attached to I/A report
_____ Completed, signed I/A report with statements, evaluations, orders, care plan placed in Unit Manager's box
_____ Completed documentation in progress notes
_____ Place on alert charting

Nurses Signature: _____ Date: _____

11/2010 kmp

INCIDENT/ACCIDENT REPORT

Resident Name: _____ Room No. 207

Date 02/08/11 Time 1315 AM☐ PM☑ Male☑ Female☐

Exact Location of Incident: Resident Rm☒ Bathroom☐ Hallway☐ (specify)_____

Outside☐ Shower Rm☐ Dining Rm☐ Restorative Rm☐ Activity Rm☐ Beauty Shop☐ Off Premises☐

Mental Status: Alert☐ Cognitively Impaired☐ Confused☐ Oriented☐ Disoriented☐ Non-responsive☒

Describe Incident: Found on Floor☐ Stood and Fell☐ Slipped on Floor☐ Resident to Resident☐

Staff to Resident☐ During Transfer☐ Slid From W/C☐ Fell OOB☐ Other ✓

What Happened? Resident noted to have change in condition non-responsive, ↓ O2 sats abnormal VS -

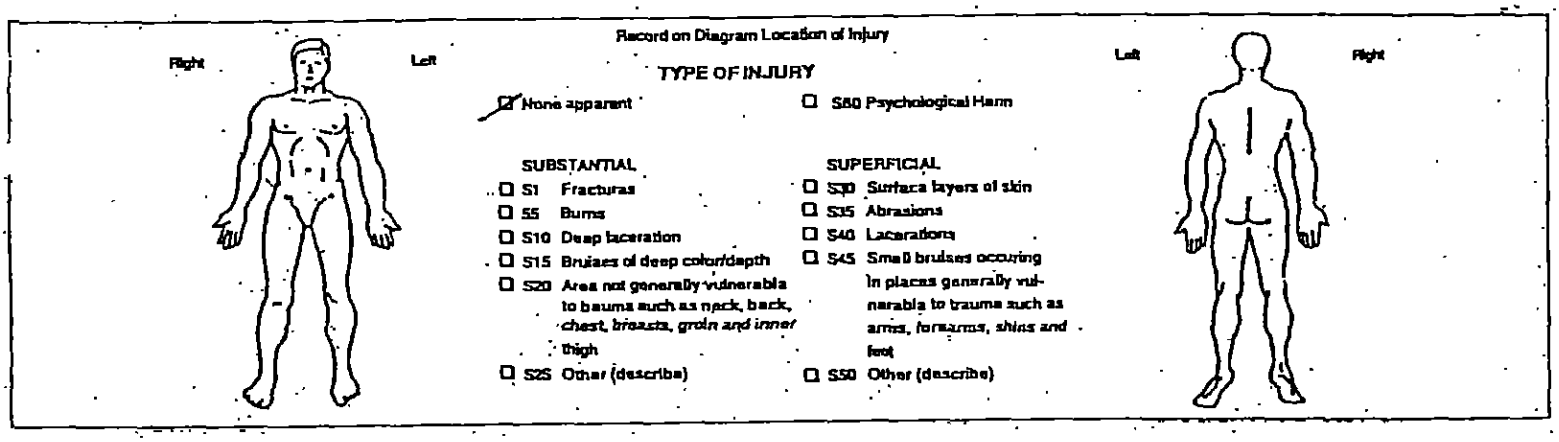
Vital Signs: BP 118/58 T 95 P 108 R 20 C/O Pain? (location) Non-responsive

Ortho BP: Lying _____ Sitting _____ Standing _____ Range of Motion _____

Injuries: Yes☐ No☑ (If yes, check all that apply on the diagram below)

Location (Include size, depth, color, pain, bleeding and limitation of motion) _____

Treatment Provided: Ice☐ Heat☐ X-ray☐ Dressing☐ Assessment/ROM☐ ER☑ (where) GHCH



Environmental Factors: Side Rails: Up☐ Down☐ N/A☑ Floor Wet: Yes☐ No☐ Wearing Shoes: Yes☐ No☐

Call Light in Place: Yes☐ No☐ W/C Brakes Locked: Yes☐ No☐ Wearing Non-skid socks: Yes☐ No☐

Were There Any Equipment Problems: Yes☐ No☐ (if yes explain) N/A

Medications:

Pain Med Used: Yes☐ No☑ Diuretic Used: Yes☐ No☑ Vasodilator Used: Yes☐ No☑

Restraint Used: Yes☐ No☑ Psychotropic Used: Yes☐ No☑ Recent Changes in Status: Yes☑ No☐

Explain: _____

Family/Representative Notified? Date 020911 Time 0930 Who Renee By Whom Charlene LPN

Physician Notified? Date 020911 Time 0930 Who Dr Barber By Whom Stone R. Orders? O

Initial When Done: Placed on Alert N/A ___ Placed on 24-hour report ___ Temp Care Plan ___ ADL Flow sheet _____

K Stone RN — Signature and Title of Person Preparing Report

020911 — Date

1130 — Time

Montesano Health and Rehabilitation
Accident / Incident Investigation

WITNESS STATEMENT

Date:_____

Resident Name:_____

Conclusion continued -
~~Statement:~~ Narcan administered will result in false (+) - Resident was septic upon admission and returned + diagnosis of MESA in urine which would have been indicative of ↓ LOC.
Although conclusion cannot positively state Oxycodone was or wasn't administered it is more than likely 1) (+) was from Narcan 2) ↓ LOC was from Sepsis -

Who was the *NAC* assigned to care for this resident on:

This shift? _____ The previous shift?_____

Who was the *LN* assigned to care for this resident on

This shift? _____ The previous shift? _____

Witness Signature: _____

Montesano Health and Rehabilitation
Accident / Incident Investigation

WITNESS STATEMENT

DATE: _____
Resident Name: _____

Statement:

Noted by LN @ 2345 to have change in LOC - Non-responsive & O2 sats - Abnormal VS. BP 118/58 T 95 Pulse 108 R 20 - O2 Sats "below 89%".
Post discussion c family out to ER for eval and subsequent admission -
RCM notified by LN @ 0357 of ER eval and admission - Narcotic count correct on 3 LTC carts - Pixis information pulled x last 48° c/o abnormal findings -
2 - PRN Oxycodone given on LTC 2/8/11 c One @ 1330 which was witnessed by RCM. Second @ 1440 in room 202-1 Resident is alert, orientated and makes own needs known. Routine Oxy residents received no PRN Oxy on 2-8-11.
- Payless Pharmacy Contacted regarding med verification
- Hot line notified of investigation
- Evening Shift LN witness Statement
- Spoke c "James" in CCU @ GHCH - MI: residents condition
0815 and request for confirmation of + oxycodone screen
0945 - Updated ih - Buben MI: residents admission
- Room check done for possible medication storage
- Resident ate "Crab" on Tuesday brought from outside vendor

Witness Signature: _____

Montesano Health and Rehabilitation
Accident / Incident Investigation

WITNESS STATEMENT

DATE: _____
Resident Name: _____

Statement:

1500 - Called CCU re: re-check of confirmation of Oxy in UA "Nurse c pt, will call back"
1645 - Medical director called re: D/C's from hospital regarding UA confirmation
1640 - CCU called "nurse busy" will call back.
1700 - Spoke c PCP Dr Buben who will contact PHCH re: additional testing to c/o Pos Urine/ false positive results for oxycodone
1930 - Spoke c Dr Buben who stated hospital will do additional studies to ascertain + or - results. Informed PCP that resident denied Narcan 25 minutes prior to UA and research supports Naltrexone resulting in false positive
02/4/11 Resident returned to facility - sepsis - MRSA in urine - on IBT
Send out lab + for oxycodone. However this was same sample - not a new sample -

Witness Signature: _____

Quest Diagnostics Incorporated

PATIENT INFORMATION
2 - Healthcare Information Rea...

REPORT STATUS Final

QUEST DIAGNOSTICS INCORPORATED

ORDERING PHYSICIAN

DOB: 2 - Healthcare Inf... Age: 90
GENDER: M Fasting: U

CLIENT INFORMATION
2 - Healthcare Information Readily Identifiable to a Pe...

SPECIMEN INFORMATION
SPECIMEN: OW4641866F
REQUISITION: 6757207
LAB REF NO: 2-9-11

COLLECTED: 02/09/2011 18:18
RECEIVED: 02/11/2011 03:50
REPORTED: 02/16/2011 16:35

COMMENTS: NONPHYS PROVIDER GIVENS

Test Name	In Range	Out of Range	Reference Range	Lab
OXYCODONE SCREEN AND CONFIRMATION, URINE				AMD
OXYCODONE		POSITIVE		
OXYCODONE	2200		ng/mL	
COMMENT	SEE NOTE			

The submitted urine specimen was screened at the initial test level listed below. If positive, confirmatory testing was performed with the confirmation test level listed below. Confirmatory testing not performed on negative screens.

Analyte	Initial Test Level	Confirmation Test Level
Oxycodone	100 ng/mL	100 ng/mL

Performing Laboratory Information:

AMD Quest Diagnostics Nichols Institute-Chantilly VA 14225 Newbrook Dr Chantilly VA 20151
Laboratory Director: Kenneth Sloan M.D.

IDENTIFICATION
This 90-year-old male presents from Montesano Health and Rehabilitation Center because of the sudden onset of change in mental status. He responded some to Narcan initially and now has decreasing mental status. He was intubated in the emergency department.

HISTORY OF PRESENT ILLNESS
He was in his usual state of fair health, living at Montesano Health and Rehabilitation Center with his wife. His son reports that he saw the patient at lunch and he was in his usual state of health. Then, reportedly, he was found to be obtunded with shallow respirations. He had only moaning. He did wake up for the paramedics briefly after Narcan. At that time, he was transferred to the emergency department.

There, his paperwork showed he was DNR and they contacted the family. The patient was started on a Narcan drip. Because of intubation, he was given empiric ceftriaxone, 1 gram IV, normal saline boluses, and Zosyn 3.375 mg.

It was decided that the patient required intubation due to increasing difficulty protecting his airway. He had hypotension, responding to IV fluids. Upon talking with the family, he told his family that he wanted intubation if it was thought to be reversible, and the decision was made to pursue intubation.

After intubation, part of the workup included a toxicology screen, which was positive for oxycodone. The nursing home was contacted again and there was reportedly no prescribed oxycodone and no obvious thought how the patient could receive oxycodone.

His blood sugar at the time was 253. His family said this was a sudden change in his mental status. He has required intubation at times in the past and has had episodes of urinary tract infections, thought to be secondary to methicillin-resistant Staphylococcus aureus. He has had significant peripheral vascular disease and has been on chronic medications. He has had no fevers, chills, or other complaints.

ALLERGIES
1. BACTRIM.
2. CLINDAMYCIN.

PAST MEDICAL HISTORY
1. Peripheral vascular disease, status post amputation bilaterally above the knee.
2. Hypertension.
3. GERD.
4. Peptic ulcer disease.
5. Hyperlipidemia.
6. BPH.

BP 118/58 Temp 95 Pulse 108 resp.

CONDITION CHANGE FORM

STATUS CHANGE Sent to ER for eval, and treat. r/t Δ in LOC per family request. O2 below 89% on 5L O2 per mask, non-responsive. Rec. Phone call from Roy @ GHCHER for (+) Oxycodone test, no oxycodone administered to resident, this writer. Left via ambulance @ about midnight

THIS REQUIRES CHANGING OF

CF	PHYSICIANS ORDERS
	ASSESSMENT
CF	CARE PLAN
	ICD CODE
CF	DISTRIBUTE TO APPROPRIATE DISCIPLINE

FAMILY NOTIFIED? ☒ YES ☐ NO RESIDENT NOTIFIED? ☐ YES ☐ NO PHYSICIAN NOTIFIED? ☒ YES ☐ NO

DATE 2/9/11 NURSE'S SIGNATURE C. Finn LPN

RESIDENT NAME [redacted] RESIDENT # [redacted] ROOM # 207-1

White/Nurses Notes Yellow/DNS Pink/Computer Gold/Discipline

CARE PLAN UPDATE

MF # = MASTER FILE NUMBER FROM CARE COMPLEX

PROBLEM / MF #	GOAL / MF #	APPROACH / MF #	DISC.
AIMN LOC — ↓OXYGENATION: O2 SATS < 80% ON 5L	to be evaluated in ER	O2 per mask Family notified RCP/Notified Sent to ER for eval.	

DISCIPLINE(S) REASSESSMENT DATE

DATE NURSE'S SIGNATURE

RESIDENT NAME Foulds, Ronald RESIDENT #

White/Care Plan Yellow/DNS Pink/Computer Gold/Extra

Form 3060 BRIGGS, Des Moines, IA 50306 (800) 247-2343 PRINTED IN U.S.A.

PHYSICIAN TELEPHONE ORDERS

FACILITY NAME/ADDRESS MHR.

RESIDENT NAME [redacted] ROOM # 207-1 PHYSICIAN Bubera

ORDER DATE	ORDER TIME	mo	CODE	PHYSICIAN ORDERS / NURSING - Circle One	SIG.	INIT.
2/9/11				Sent to ER per family request r/t significant Δ in Condition. T.O. Bubera/Charles Finn LPN		
Noted 2/9/11 CF						

NURSE SIGNATURE X C. Finn LPN DATE

PHYSICIANS SIGNATURE X MD 2011-153821-000036 DATE

Form 3060 © BRIGGS, Des Moines, IA 50306 www.BriggsCorp.com

PHYSICIAN PLEASE SIGN AND RETURN

This LN was notified of resident transport and admission to GHCH at 0357, I entered MHR at 0600 and started investigation, did a room check with the noc shift LN to look for any outside medications, witnessed narc count to all three med carts on LTC, pulled last 48 hour pixis info about stock and pulls, looked at the residents on the hall and no one except two residents received PRN, one at 1330 witnessed by this LN, and the other to a alert resident at 1440, both residents are alert and orientated None of the residents with a routine oxycodone at either 1800 or 2000 received any prn for break through pain.

Will contact Payless pharmacy to send back current medications to verify that what is on the label is what it is suppose to be.

Pm LN called at 0719 message left to contact either RCM, DNS or administrator and that we need her to come in the MHR.

State hotline called at 0740.

Medical director patients pcp called at 0950, stated to have ghch re-test to rule out a false positive, info forwarded to GHCH .

NURSE'S NOTES

Name _____ Doctor _____ Room No. _____

Date and Time	2-9-11	Nurse's Name
	Mr. [redacted] was alert, oriented ev shift of 2-8-11. He was up to dining room per usual. self-propelled W/C. ate dinner. o s/s pain or discomfort. o request for pain meds. None given. Rebecca Knoll LPN	

PayLess

MEDICATIONS RETURNED TO PAYLESS PHARMACY

Pharmacy to Complete:

Facility mhr

Completed By Kgardner

Patient Name
One Patient per form

Date 2-9-11

Date Rec'd

Verified By

Facility to Complete:

Rx#	Drug	Strength	Quantity	Return Reason Code	Denial Code	Credit = ✓
61561561	Sucralfate 1gm		96	F		
61325481	flomax	0.4mg	43			
61325721	Diovan	80mg	20			
61325541	K-Tab	10meq	8			
61326071	Norvasc	5mg	54			
61325701	omeprazole DR	80 → 40mg	40			
61357201	Requip	1mg	13			

FACILITY RETURN REASON CODE:

A = Med Discontinued	D = Med Change
B = Moved out of Facility	E = Error
C = Patient Expired	F = Other

CONTROLLED DRUGS (Schedule II, III, IV, V of Federal Comprehensive Drug Abuse Prevention control Act of 1970) CANNOT be returned for credit. They must be destroyed on Premise per state and Federal Law.

DENIAL CODE:

1 = Below Minimum $
2 = Medicaid
3 = Damaged
4 = Form Incomplete
5 = Other

* Complete this portion:

C = Patient Expired, Date _____

D = Medication Change, Specify _____
(For Medication Change, please call Customer Care immediately at (503) 626-9436 or (800) 330-3665.)

E = Error, Specify _____
(For Medication Error, please call Customer Care immediately at (503) 626-9436 or (800) 330-3665.)

F = Other, Specify please verify that the drug on label is what is on blister

Notes to PayLess _____

- Medications must be returned within **30 days of Fill Date** in order to be considered for credit.
- No Return Form needed if only 1 to 3 pills remaining in bubble pack card.
- For questions regarding returns, please dial (503) 372-1761 or (800) 330-3665 ext: 1761.

PayLess

MEDICATIONS RETURNED TO PAYLESS PHARMACY

Pharmacy to Complete:

Facility mhr

Completed By Kgardner

Patient Name
One Patient per

Date 2-9-11

Date Rec'd

Verified By

Facility to Complete:

Rx#	Drug	Strength	Quantity	Return Reason Code	Denial Code	Credit = ✓
6281402	finasteride	5mg	14$	F		
6714226	Remeron	15mg	35$	F		
6162792	Celexa	20mg	29	F		

FACILITY RETURN REASON CODE:

A = Med Discontinued	D = Med Change
B = Moved out of Facility	E = Error
C = Patient Expired	F = Other

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E = Error, Specify_____
(For Medication Error, please call Customer Care immediately at (503) 626-9436 or (800) 330-3665.)

F = Other, Specify verify Drug on label & in blister are same

Notes to PayLess_____

- Medications must be returned within **30 days of Fill Date** in order to be considered for credit.
- No Return Form needed if only 1 to 3 pills remaining in bubble pack card.
- For questions regarding returns, please dial (503) 372-1761 or (800) 330-3665 ext: 1761.

Naltrexone

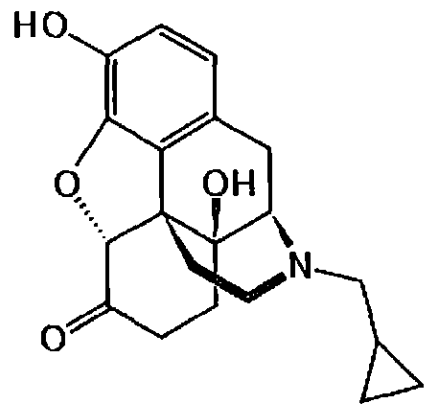
From Wikipedia, the free encyclopedia

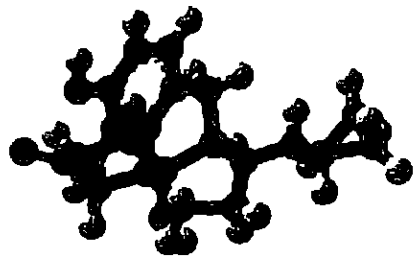
Naltrexone is an opioid receptor antagonist used primarily in the management of alcohol dependence and opioid dependence. It is marketed in generic form as its hydrochloride salt, **naltrexone hydrochloride**, and marketed under the trade names **Revia** and **Depade**. In some countries including the United States, a once-monthly extended-release formulation is marketed under the trade name **Vivitrol**. Also in the US, *Methylnaltrexone Bromide*, a closely related drug, is marketed as Relistor, for the treatment of opioid induced constipation.

Naltrexone should not be confused with naloxone (which is used in emergency cases of overdose rather than for longer-term dependence control) nor nalorphine. Both nalorphine and naloxone are full antagonists and will treat an opioid overdose, but naltrexone is longer-acting than naloxone (although neither is an irreversible antagonist like naloxazone), making naloxone a better emergency antidote.

Contents

Naltrexone





Systematic (IUPAC) name

17-(cyclopropylmethyl)-4,5α-epoxy- 3,14-dihydroxymorphinan-6-one

Identifiers

CAS number	16590-41-3
ATC code	N07BB04
PubChem	CID 5360515
IUPHAR ligand	1639
DrugBank	APRD00005
ChemSpider	4514524 ✓
UNII	5S6W795CQM ✓
ChEMBL	CHEMBL142 ✓

Chemical data

Formula	$C_{20}H_{23}NO_4$
Mol. mass	341.401 g/mol
SMILES	eMolecules & PubChem

InChI

InChI=1S/C20H23NO4/c22-13-4-3-12-9-15-20(24)6-5-14(23)18-19(20,16(12)17(13)25-18)7-8-21(15)

Chemical structure

Naltrexone can be described as a substituted oxymorphone – here the tertiary amine methyl-substituent is replaced with methylcyclopropane.

Naltrexone is the N-cyclopropylmethyl derivative of oxymorphone.

10-11-1-2-11/h3-4,11,15,18,22,24H,1-2,5-10H2/t15-,18+,19+,20-/m1/s1 ✓	
Key: DQCKKXVULJGBQN-XFWGSAIBSA-N ✓	
Physical data	
Melt. point	169 °C (336 °F)
Pharmacokinetic data	
Bioavailability	5–40%
Protein binding	21%
Metabolism	hepatic
Half-life	4 h (naltrexone), 13 h (6-β-naltrexol)
Excretion	renal
Therapeutic considerations	
Pregnancy cat.	Category B3 (Australia)
Legal status	Schedule 4 (Australia)
Routes	oral hepatic
✓ **(what is this?) (verify)**	

Pharmacology

Naltrexone and its active metabolite 6-β-naltrexol are competitive antagonists at μ- and κ-opioid receptors, and to a lesser extent at δ-opioid receptors.[1] The plasma halflife of naltrexone is about 4 h, for 6-β-naltrexol 13 h. The blockade of opioid receptors is the basis behind its action in the management of opioid dependence—it reversibly blocks or attenuates the effects of opioids.

Its use in alcohol (ethanol) dependence has been studied and has been shown to be effective [1]. Its mechanism of action in this indication is not fully understood, but as an opioid-receptor antagonist it's likely to be due[*citation needed*] to the modulation of the dopaminergic mesolimbic pathway which is hypothesised to be a major center of the reward associated with addiction (being one of the primary centers for risk-reward analysis in the brain, and a tertiary "pleasure center") that all major drugs of abuse are believed to activate.

Naltrexone is metabolised mainly to 6β-naltrexol by the liver enzyme dihydrodiol dehydrogenase. Other metabolites include 2-hydroxy-3-methoxy-6β-naltrexol and 2-hydroxy-3-methoxy-naltrexone. These are then further metabolised by conjugation with glucuronide.

Rapid detoxification

Naltrexone is sometimes used for rapid detoxification ("rapid detox") regimens for opioid dependence. The principle of rapid detoxification is to induce opioid-receptor blockage while the patient is in a state of impaired consciousness, so as to attenuate the withdrawal symptoms experienced by the patient. Rapid detoxification under general anaesthesia involves an unconscious patient and requires intubation and external ventilation. Rapid detoxification is also possible under sedation. The rapid detoxification procedure is followed by oral naltrexone daily for up to 12 months for opioid dependence management. There are a number of practitioners who will use a naltrexone implant, usually placed in the lower abdomen, to replace the oral naltrexone. This implant procedure has not been shown scientifically to be successful in "curing" subjects of their addiction, though it does provide a better solution than oral naltrexone for medication compliance reasons. There is currently scientific disagreement as to whether this procedure should be performed under local or general anesthesia, due to the rapid, and sometimes severe, withdrawal that occurs from the naltrexone displacing the opiates from the receptor sites.

Rapid detoxification has been criticised by some for its questionable efficacy in long-term opioid dependence management.[2] Rapid detoxification has often been misrepresented as a one-off "cure" for

opioid dependence, when it is only intended as the initial step in an overall drug rehabilitation regimen. Rapid detoxification is effective for short-term opioid detoxification, but is approximately 10 times more expensive than conventional detoxification procedures. Aftercare can also be an issue,[2] since at least one well-known center in the United States reported that they will remove an implant from any patient arriving in their facility before admission.[*citation needed*]

The usefulness of naltrexone in opioid dependence is very limited by the low retention in treatment. Like disulfiram in alcohol dependence, it temporarily blocks substance intake and does not affect craving. Sustained-release preparations of naltrexone have shown rather promising results, it remains a treatment only for a small part of the opioid-dependent population, usually the ones with an unusually stable social situation and motivation (e.g., dependent health care professionals). It is given orally by physicians to help reduce the side effects of opiate dependence. Naltrexone implants have been used successfully in Australia for a number of years as part of a long-term protocol for treating opiate addiction. Naltrexone treats the physical dependence on opioids, but further psychosocial interventions are often required to enable people to maintain abstinence.[3]

Alcohol dependence

The main use of naltrexone is for the treatment of alcohol dependence. After publication of the first two randomized, controlled trials in 1992, a number of studies have confirmed its efficacy in reducing frequency and severity of relapse to drinking.[4] The multi-center COMBINE study has recently proven the usefulness of naltrexone in an ordinary, primary care setting, without adjunct psychotherapy.[5]. Mechanism of action may be antagonism to endogenous opiates such as tetrahydropapaveroline, whose production is augmented in the presence of alcohol.[6]

The standard regimen is one 50 mg tablet per day. Initial problems of nausea usually disappear after a few days, and other side effects (e.g., heightened liver enzymes) are rare. Drug interactions are not significant, besides the obvious antagonism of opioid analgesics. Naltrexone has two effects on alcohol consumption.[7] The first is to reduce craving while naltrexone is being taken. The second, referred to as the Sinclair Method, occurs when naltrexone is taken in conjunction with normal drinking, and this reduces craving over time. The first effect persists only while the naltrexone is being taken, but the second persists as long as the alcoholic does not drink without first taking naltrexone.

Roy Eskapa, who wrote a book advocating the Sinclair Method, argues that Naltrexone does not work in conjunction with abstinence.[8] Eskapa cites as evidence a Finnish clinical trial in which "Naltrexone tended to be worse than those for placebo,"[9] and two studies that produced "almost identical graphs": an alcoholism clinical trial at Yale[10] and a Nalurexone for cocaine addiction trial at the University of Texas.[11]

Depot injectable naltrexone (Vivitrol, formerly Vivitrex, but changed after a request by the FDA) was approved by the FDA on April 13, 2006 for the treatment of alcohol dependence.[12] This version is made and marketed by Alkermes in the United States, and is marketed by Johnson & Johnson in Russia. Cephalon Inc. originally marketed the drug in the United States, however, Alkermes reclaimed Vivitrol commercialization rights in 2008.[13] The recommended dose of Vivitrol 380 mg is delivered intramuscularly once a month. The injection should be administered by a healthcare professional.[14]

The clinical trial that the approval of Vivitrol was based on showed that when compared with a placebo, 380 mg of Vivitrol resulted in a 25% decrease in the event rate of heavy drinking days and 190 mg

resulted in a 17% decrease. The 6-month randomized, double-blind, placebo-controlled study was conducted between February 2002 and September 2003. Of the 899 individuals screened, 627 were diagnosed as alcohol-dependent adults and were randomized to receive treatment. The main outcome measure was the event rate of heavy drinking days in the intent-to-treat population. The study's authors concluded that: "Long-acting naltrexone was well tolerated and resulted in reductions in heavy drinking among treatment-seeking alcohol dependent patients during 6 months of therapy."[15]

Another study released by the National Institute of Health in February 2008 and published in the *Archives of General Psychiatry* has shown that alcoholics having a certain gene variant of the opioid receptor were far more likely to experience success at cutting back or discontinuing their alcohol intake altogether.[16]

Opiate addiction

Naltrexone helps patients overcome urges to abuse opiates by blocking the drugs' euphoric effects. While some patients do well with the oral formulation, there is a drawback in that it must be taken daily, and a patient whose craving becomes overwhelming can obtain opiate euphoria simply by skipping a dose before resuming abuse.

The FDA approved Vivitrol, the long-acting version of naltrexone, on October 12, 2010 for the prevention of relapse to opioid dependence, following opioid detoxification. "This drug approval represents a significant advancement in addiction treatment," said Janet Woodcock, M.D., director of the FDA's Center Drug Evaluation and Research.[17]

Nora Volkow, M.D., Director of the National Institute on Drug Abuse (NIDA), stated that: "As a depot formulation, dosed monthly, Vivitrol obviates the daily need for patients to motivate themselves to stick to a treatment regimen - a formidable task, especially in the face of multiple triggers of craving and relapse. This new option increases the pharmaceutical choices for treating opioid addiction, and may be seen as advantageous by those unwilling to consider agonist or partial agonist approaches to treatment. NIDA is continuing to support research on Vivitrol's effectiveness in this country, including a focus on criminal justice involved populations transitioning back into the community."[18]

The phase 3 clinical study upon which the FDA granted approval for Vivitrol in treating opioid dependence had an enrollment of 250. Primary outcome measures were percent of weekly urine tests that were negative for opioids and the length of the study retention during the double-blind period. The study began in June 2008 and was completed in November 2009.

Alkermes presented positive results from the phase 3 clinical study of Vivitrol for the treatment of opioid dependence at the American Psychiatric Association 2010 Annual Meeting in May 2010. The study met its primary efficacy endpoint and data showed that patients treated once-monthly with Vivitrol demonstrated statistically significant higher rates of clean (opioid-free) urine screens, compared to patients treated with a placebo, as measured by the cumulative distribution of clean urine screens ($p<0.0002$).[19] The results of the study are expected to be published soon.

Another option for the treatment of opiate addiction is the naltrexone implant, which may be surgically inserted under the skin. The implant provides a sustained dose of naltrexone to the patient, thereby preventing the problems which may be associated with skipping doses. It must be replaced every several months. Naltrexone implants are made by at least three companies, though none have been approved by the U.S. Food and Drug Administration (FDA) or the Australian Therapeutic Goods Administration.[20]

Safety

In alcohol dependence, naltrexone is considered a safe medication. Control of liver values prior to initiation of treatment is recommended. There has been some controversy regarding the use of opioid-receptor antagonists, such as naltrexone, in the long-term management of opioid dependence due to the effect of these agents in sensitising the opioid receptors. That is, after therapy, the opioid receptors continue to have increased sensitivity for a period during which the patient is at increased risk of opioid overdose. This effect reinforces the necessity of monitoring of therapy and provision of patient support measures by medical practitioners.

Other uses

Low dose naltrexone (LDN)

Main article: Low dose naltrexone

Low dose naltrexone (LDN), where the drug is used in doses approximately one-tenth those used for drug/alcohol rehabilitation purposes, is being used by some as an "off-label" experimental treatment for certain immunologically-related disorders,[21] including HIV/AIDS,[22] multiple sclerosis[23] (in particular, the primary progressive variant,[24]) cancer,[25] fibromyalgia,[26] autoimmune diseases such as[*citation needed*] rheumatoid arthritis, ankylosing spondylitis, transverse myelitis, Crohn's disease, ulcerative colitis, Hashimoto's thyroiditis, and central nervous system disorders.[*citation needed*] Certain medications will work against the naltrexone such as Hydrocodone, Oxycodone, Oxymorphone and other opiate/opioid narcotics.[*citation needed*] These medications should not be taken while on Naltrexone, as nausea, vomiting, cold sweats, chills, and sometimes numbness in the limbs may occur.[*citation needed*] Naltrexone may also interfere or counteract both low and high doses of over-the-counter NSAID medications.[*citation needed*]

One study showed that LDN did not help with Parkinson's disease.[27]

Sexual dysfunction

Naltrexone can induce early morning erections in patients who suffer from psychogenic erectile dysfunction. The exact pathway of this effect is unknown. Priapism has been reported in two individuals receiving Vivitrol.

Naltrexone has been shown to be effective in the reversal of sexual satiety and exhaustion in male rats.[28]

Tobacco study

The Chicago Stop Smoking Research Project at the University of Chicago studied whether naltrexone could be used as an aid to quit smoking. The researchers discovered that Naltrexone improved smoking cessation rates in women by fifty percent, but showed no improvement for men.[29]

Use for Crohn's disease

In a clinical trial conducted by Pennsylvania State University, it was concluded that low dose naltrexone helped people with Crohn's disease, putting the disease into remission in many cases, though it was stated that further study would be required.[30]

Self-injurious behaviors

Some studies suggest that self-injurious behaviors present in developmentally disabled and autistic people can sometimes be remedied with naltrexone.[31] In these cases, it is believed that the self-injury is being done to release beta-endorphin, which binds to the same receptors as heroin and morphine.[32] By removing the "rush" generated by self-injury, the behavior may stop.

Kleptomania

There are indications that naltrexone might be beneficial in the treatment of impulse control disorders such as kleptomania (compulsive stealing), trichotillomania, or pathological gambling.[33]

Study in overweight and obese patients

Clinical trials are ongoing regarding the use of naltrexone in combination with another drug, bupropion, as a weight loss therapy.[34]

Autism

Dr. Jaak Panksepp of Washington State University has conducted studies using naltrexone to treat patients with autism. He found that half the autistic children treated with the drug become more social. [35]

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External links

Low dose naltrexone

- Low Dose Naltrexone Homepage Research and details on using LDN to treat various diseases.
- Those Who Suffer Much Know Much, July 2010 is a free book containing 51 low dose naltrexone health case studies, 19 health professional interviews and perspectives, studies, trials, and related references; produced by Cris Kerr of Case Health as a community service. (A big file, allow a few seconds to open.)
- LDN Research Trust UK [2]
- '201 Reasons Why... You Should Know about LDN' from the LDN Research Trust, UK is a free book containing 201 patient testimonies of improved health using LDN.
- AHSTA.com Low-dose Naltrexone in Thyroid Autoimmunity Homepage
- Elaine A. Moore, SammyJo Wilkinson, The Promise of Naltrexone: Potential Benefits of Low Dose Therapy for Patients with Cancer and Neurodegenerative and Autoimmune Disorders Jefferson, NC: McFarland and Company, 2008.

Retrieved from "http://en.wikipedia.org/wiki/Naltrexone"
Categories: Opioid antagonists | Alcohol abuse | Morphinans | Phenols | Ketones | Alcohols | Semisynthetic opioids | Ethers

Evaluation of Opiate results

Cut-off value

300 ng/mL

Cross-reactivity

This assay detects morphine, heroin (diacetylmorphine), 6-monoacetyl morphine, codeine, dihydrocodeine, hydrocodone, hydromorphone, and oxycodone (in high levels).

This assay will not detect methadone or buprenorphine (a buprenorphine assay is available at an extra charge).

Metabolism

Heroin (half-life = 10 minutes) is rapidly metabolised to 6-monoacetyl morphine and morphine. 80% of the dose is excreted within 24 hours.

Morphine (half-life = 2 hours) is metabolised to morphine-3 and morphine-6 glucuronides. 84% of the dose is excreted within 8 hours.

Codeine (half-life = 3 hours) is metabolised to morphine (except in 10% of the Caucasian population) and norcodeine. 86% of the dose is excretad within 24 hours.

Dihydrocodeine (half-life = 4 hours) is metabolised to nordihydrocodeine and dihydromorphine. 20–30% of the dose is excreted within 24 hours.

Hydrocodone (half-life = 4 hours) is a metabolite of codeine. 26% of the dose is excreted in 72 hours. Hydrocodone is metabolised to hydromorphone.

Hydromorphone (half-life = 1.5–4 hours). 36% of the dose is excreted within 72 hours.

Heroin, morphine, and their metabolites are usually detectable *for 36–48 hours following a standard dose.*

Some of these compounds are present in prescription and over-the-counter preparations. Thin Layer Chromatography (or Gas Chromatography/Mass Spectrometry [GC/MS], if the results will be used for medico-legal purposes) is available on request to identify any cross-reacting compound present, if this is suspected.

Interferences

High levels of naltrexone may cause false positive results.

Activity Report

MONTESANO

Report Options V4.0
Group by: Patient Name
Sort by: Tx Time and Item Name 1 and User Name
Through Tx Time 2011-02-07 00:00:01 and 2011-02-08 07:00:00
All Patient Name
All Item Name 1
All Item Class
All Owner Id
All User Name
All Transaction

* NON PATIENT SPECIFIC ACTIVITY *

40 ..... Inventory 02/08/11 04:10:18
OXYCODONE 5MG TABS (OXY5)
From: 002-028 1x1 0000C7A588 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 38/40
*** Discrepancy: Expected 38,Found 40 ***

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2 ..... Refill 02/08/11 06:12:11
HYDROCODONE/APAP 5/500 TABS (HYDROCO5500)
From: 002-005 1x2 00008BF27C By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 31/33

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1 ..... Refill 02/08/11 06:12:23
OXYCODONE 5MG TABS (OXY5)
From: 002-028 1x1 0000C7A588 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 38/39

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2 ..... Refill 02/08/11 06:13:06
HYDROCODONE/APAP 7.5/500MG TAB (HYDROCO75500)
From: 002-028 1x1 0000C7A582 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 28/30

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2 ..... Refill 02/08/11 06:14:48
CIPROFLOXACIN 250MG TABS (CIPRO250)
From: 001-027 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 27/29

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1 ..... Refill 02/08/11 06:14:58
CARVEDILOL 12.5MG TAB (CARVE012.5)
From: 001-034 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 7/8

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2 ..... Refill 02/08/11 06:15:11
METRONIDAZOLE 250MG TABS (METRON250)
From: 004-005 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 8/10

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2 ..... Refill 02/08/11 06:15:21
ONDANSETRON 4MG TAB (ONDAN4)
From: 004-015 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 4/6

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2 ..... Refill 02/08/11 06:15:33
NITROFURANTOIN 50MG CAPS (NITRO50)
From: 004-018 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 4/6

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1 ..... Refill 02/08/11 06:15:43
POTASSIUM CHLORIDE 10MEQ CAP (POT10MEQ)
From: 005-038 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 18/20

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2 ..... Refill 02/08/11 06:15:51
LISINOPRIL 10MG TAB (LISIN10)
From: 005-044 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 13/15

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2 ..... Refill 02/08/11 06:18:04
FRAGMIN(2500)IU (FRAG2500)

2 - Healthcare Informatio... (!8881288825218)

2 ..... Remove 02/07/11 17:58:33
MORPHINE SULFATE ER 15 MG TABS (MSER15)
From: 002-007 1x2 00010BABDC By: SUSAN MOE (SEM)
Beg/End Dispense Amount: 28/28
For: 2 - Healthcare Info... (!8881288825218)

2 - Healthcare Informat... (221325)

1 ..... Remove 02/08/11 07:53:28
DEXTROSE 50% INJ SYR (DEXTR50)
From: 005-013 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 4/3
For: 2 - Healthcare In... (221325)

0 ..... Remove 02/08/11 07:53:48
CLAVE/ULTRASITE (VIAL ADAPTER) (VIALADAP)
From: 008-034 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 4/4
For: 2 - Healthcare In... (221325)

0 ..... Remove 02/08/11 07:55:26
IV CATHETER 22G (IVCATH22)
From: 008-014 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 5/5
For: 2 - Healthcare Inf... (221325)

2 - Healthcare Inf... (8717110)

1 ..... Remove 02/07/11 18:55:27
LIPITOR 10MG TAB (LIPIT10)
From: 001-013 By: GRIGGS GLORIA (GG)
Beg/End Dispense Amount: 15/14
For: 2 - Healthca... (8717110)

2 - Healthcare Infor... (221317)

2 ..... Remove 02/07/11 15:31:37
CEPHALEXIN 250MG CAPS (CEPH250)
From: 001-018 By: REAGAN PIPER (RKP)
Beg/End Dispense Amount: 30/28
For: 2 - Healthcare ... (221317)

2 ..... Remove 02/07/11 23:48:02
CEPHALEXIN 250MG CAPS (CEPH250)
From: 001-018 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 28/28
For: 2 - Healthcare I... (221317)

2 - Healthcare Informatio... (!8821293140743)

2 ..... Remove 02/08/11 09:30:47
PHENAZOPYRIDINE 100MG TAB (PHENAZ100)
From: 005-024 By: SIMBE,BRIANA (BS)
Beg/End Dispense Amount: 10/8
For: 2 - Healthcare Info... (!8821293140743)

2 ..... Remove 02/08/11 12:08:32
PHENAZOPYRIDINE 100MG TAB (PHENAZ100)
From: 005-024 By: SIMBE,BRIANA (BS)
Beg/End Dispense Amount: 8/8
For: 2 - Healthcare Inf... (!8821293140743)

2 - Healthcare Infor... (221315)

2 ..... Remove 02/07/11 05:10:28
HYDROCODONE/APAP 5/500 TABS (HYDROCO5500)
From: 002-005 1x2 00008BF27C By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 33/31
For: 2 - Healthcar... (221315)

2 ..... Remove 02/08/11 12:08:32
PHENAZOPYRIDINE 100MG TAB (PHENAZ100)
From: 005-024 By: SIMBE,BRIANA (BS)
Beg/End Dispense Amount: 8/8
For: 2 - Healthcare Infor... (8821283140743)

2 - Healthcare Infor... (221315)

2 ..... Remove 02/07/11 05:10:28
HYDROCODONE/APAP 5/500 TABS (HYDROCO5500)
From: 002-005 1x2 00008BF27C By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 33/31
For: 2 - Healthcare... (221315)

1 ..... Remove 02/08/11 04:08:44
OXYCODONE 5MG TABS (OXY5)
From: 002-028 1x1 0000C7A588 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 39/38
For: 2 - Healthcar... (221315)

1 ..... Remove 02/08/11 04:11:10
OXYCODONE 5MG TABS (OXY5)
From: 002-028 1x1 0000C7A588 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 40/39
For: 2 - Healthcare... (221315)

1 ..... Remove 02/08/11 04:23:11
OXYCODONE 5MG TABS (OXY5)
From: 002-028 1x1 0000C7A588 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 39/38
For: 2 - Healthcar... (221315)
Dose?

2 - Healthcare Infor... (!6831221341803)

0 ..... Remove 02/07/11 05:14:18
CYANOCOBALAMIN (B12) 100DMCO (VITB12)
From: 808-015 By: MATTSON, JACOB (JMM)
Beg/End Dispense Amount: 1/1
For: 2 - Healthcare I... (!6831221341803)

2 - Healthcare Informatio... (!8801281143833)

2 ..... Remove 02/07/11 07:12:02
MORPHINE SULFATE ER 15 MG TABS (MSER15)
From: 002-007 1x2 00010BABDC By: KIM O'CONNOR (KO)
Beg/End Dispense Amount: 30/28
For 2 - Healthcare Infor... (!8901281143833)

2 - Healthcare Informat... (221322)

2 ..... Remove 02/07/11 10:12:08
FRAGMIN 2500 IU (FRAG2500)
From: 008-031 By: REAGAN PIPER (RKP)
Beg/End Dispense Amount: 3/1
For: 2 - Healthcare In... (221322)

2 ..... Remove 02/08/11 08:24:18
FRAGMIN 2500 IU (FRAG2500)
From: 008-031 By: SIMBE,BRIANA (BS)
Beg/End Dispense Amount: 3/1
For: 2 - Healthcare Inf... (221322)

Station Activity Report For Official Use Only End of Report

PEDIATRIC SAFETY / SECURITY
PINK WRISTBAND: ☐ PATIENT ☐ RESPONSIBLE ADULT
☐ RESPONSIBLE ADULT W/PATIENT AT ALL TIMES

PMD: Buben

ALLERGIES: NKDA Bactrim, Cipro

ESI 1 2 (3) 4 5 | MODE: ☑ EMS ☐ WALK ☐ W/C ☐ CARRIED ☐ SCCC ☐ POLICE

TRIAGE: TIME: 0025 CHIEF COMPLAINT: from MHR - unresponsive, pupils pinpoint - given 0.4mg Narcan - became responsive initially diaphoretic, SpO2: 79% - p med SpO2 ↑ 98% 15 L NRB BS: 253 - NO CODE

INTERVENTIONS: ☐ NONE ☐ ICE ☐ ELEVATE ☐ PRESSURE DRESSING ☐ C COLLAR ☐ BLOOD DRAW ☐ CBG RN.

TIME	TEMP	PULSE	RESP	BP	SpO2	O2
0025	(TA) R O 96.2	101	14	(B) 127/75	92%	RA

PAIN SCORE 0 /10

TETANUS UTD (< 5 YRS) ☐ Y ☐ N
IMMUNIZATIONS (PEDS) ☐ Y ☐ N
LMP: ☐ HYST ☐ BTL

RE-V
TIME ____ Pain ____ /10 BP ____ T ____ P ____ R ____ SpO2 ____ ____ RN./EDT
TIME ____ Pain ____ /10 BP ____ T ____ P ____ R ____ SpO2 ____ ____ RN./EDT

ORDER TIME: 1.) 0026 2.) 0026 3.) ____ 4.) ____ 5.) ____

LAB

☐ CBCD	☐ CMPR	☐ BNPEP	(2) ☑ Ammonia	☐ GCSC ☐ CHLFA ☐ WTMT
☐ Hemoglobin	☐ BMPR	☐ CK	☐ Lactic Acid	☐ Stool GS ☐ STL Culture
☐ Hematocrit	☐ Uric Acid	☐ CKMB	☐ CRP	☐ Stool OP ☐ Cdiff Tox
☐ ESR	☐ Amylase	☐ TropT	☐ T&C ____ units	☐ RSV
☐ PT/INR	☐ Lipase	(1) ☑ ETOH	☐ GT Screen	☐ BSSC (Rapid Strep)
☐ PTT	☐ GGT	☐ Salicylate	☐ GT Hold	☐ UA C/S
☐ D-DIMER	☐ Ketones	☐ Acetaminophen	Other ____	(2) ☑ B Culture
☐ Influenza	☐ Dig Level	☐ RH	____	☐ 1 Set ☑ 2 Sets
☐ Mono Spot	☐ Dilantin	☐ T_4	____	☐ Ped (BCP)
☐ VBG	☐ HCG (Pregs)	☐ TSH	**PANELS**	☐ Wound Cult.
☐ ABG	☐ HCG (Quant)	(1) ☑ UAM ____ cath	(1) ☑ Cardiac	Site ____
☐ RA	☐ Preg (Urine)	(2) ☑ DOAS Urine	☐ Trauma	Source ____
☐ O_2 ____	☐ Myoglobin	☐ ECG	☐ Lumbar Puncture	☐ Sputum

X-RAYS ☐ DO NOT STAND PATIENT

☐ CXR ☐ Port. ☐ PA/LAT	R L Ankle/Foot	R L Humerus
☐ C Spine (Spiocomp)	R L Tib/Fib	R L Shoulder
☐ Lateral C Spine ☐ Port	R L Knee	R L Clavicle
☐ T Spine (Spits)	R L Femur	PT HX ____
☐ L/S Spine (Spits)	R L Hip/Pelvis	____
☐ AAS	R L Hand	____
☐ KUB	R L Wrist / FA / Elbow	____

EC
☐ Echo
☐ Carotid Doppler
☐ DVT R ____ L ____ B ____

N. MED
☐ Resting Cardiolyte
HX ____

☐ Prior ECG ☐ HP ☐ ED
☐ Old Records
Hosp. ____
When ____

NIWR 1) ____
2) ____
3) ____

D/C WHERE CCU-5
HOW STRETCHER
TIME 0450

PHYSICIAN / MID-LEVEL SIGNATURE

Grays Harbor COMMUNITY HOSPITAL

M. EDADMREC

EMERGENCY DEPARTMENT ADMISSION RECORD
ER723-501 (10/09)
PATIENT CHART

G013321377
2 - Healthcare Informat...
DOB 2 - Healt... M AGE: 90
02/09/11 ER
M0102440

RUN DATE: 02/09/11 Grays Harbor Laboratory PAGE 5
RUN TIME: 0718 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: KGRENON PCI User: KGRENON Lab Database: LAB.GRY

Patient: 2 - Healthcare Information R... #G013321377 (Continued)

Test	Day	Date	Time	Result	Reference	Units
Oxycodone	1	FEB 9	0045	(f) Abn	[NEGATIVE]	

NOTES: (f) POSITIVE Abn
See also (g)
(g) This is a screening test for clinical purposes only. A more specific alternate method must be ordered for confirmation. Clinical consideration and professional judgment should be applied when interpreting this screen. If needed, confirmation must be ordered separately.

Patient: 2 - Healthcare Information R... Age/Sex: 90/M Acct#G013321377 Unit#M0102440

RUN DATE: 02/09/11 Grays Harbor Laboratory PAGE 1
RUN TIME: 0121 SPECIAL BROADCAST
RUN USER: LABBKGJOB

Name: 2 - Healthcare Information Re... Age/Sex: 90/M Attend Dr: BUCK, JULIE M
Acct#: G0133213777 Unit#: M0102440 Status: REG ER Location: ER BD:05
Reg: 02/09/11 Disch:

SPEC #: 0209:CT00001S COLL: 02/09/11-0045 STATUS: COMP REQ #: 01226825
RECD: 02/09/11-0052 SUBM DR: BUCK,JULIE M

ENTERED: 02/09/11-0047 OTHR DR: BUBEN,MICHAEL C
ORDERED: TOX
COMMENTS: Is there a written order to confirm any positive results? N
QUERIES: The order (written or verbal) is to confirm positives N

Test	Result	Flag	Reference
Toxicology Screen of Urine			
Drugs of Abuse Cut-offs	SEE BELOW		
The following cut off concentrations are established for the drug classes screened:			
	AMP Amphetamines		*1000 ng/mL*
	mAMP Methamphetamines		*1000 ng/mL*
	BAR Barbiturates		*300 ng/mL*
	BZO Benzodiazepines		*300 ng/mL*
	COC Cocaine		*300 ng/mL*
	MTD Methodone		*300 ng/mL*
	PCP Phencyclidine		*25 ng/mL*
	THC Marijuana Metabolites		*50 ng/mL*
	TCA Tricyclic Antidepressants		*1000 ng/mL*
	OXY Oxycodone		*100 ng/mL*
Amphetamines	NEGATIVE		NEGATIVE
Methamphetamines	NEGATIVE		NEGATIVE
Barbiturates	NEGATIVE		NEGATIVE
Benzodiazepines	NEGATIVE		NEGATIVE
Cocaine (Benzoylecgnine)	NEGATIVE		NEGATIVE
Methadone	NEGATIVE		NEGATIVE
Opiates (Morphine)	NEGATIVE		NEGATIVE
Phencyclidine	NEGATIVE		NEGATIVE
THC (Marijuana)	NEGATIVE		NEGATIVE
Trycyclic Antidepressants	NEGATIVE		NEGATIVE
Oxycodone	POSITIVE	Ab	NEGATIVE

This is a screening test for clinical purposes only. A more specific alternate method must be ordered for confirmation. Clinical consideration and professional judgment should be applied when interpreting this screen. If needed, confirmation must be ordered separately.

** END OF REPORT **

RUN DATE: 02/09/11
RUN TIME: 0648
RUN USER: LABBKGJOB

Grays Harbor Laboratory
SPECIAL BROADCAST

PAGE 1

Name: [redacted] 2 - Healthcare Information R...
Acct#: G013324377 Unit#: M0102440 Age/Sex: 90/M Attend Dr: BENIS,INES N
Reg: 02/09/11 Disch: Status: ADM IN: Location: CCU 300-05

SPEC #: 0209:BG00004U
COLL: 02/09/11-0640
RECD: 02/09/11-0646
STATUS: COMP
REQ #: 01226853
SUBM DR: BUCK,JULIE M

ENTERED: 02/09/11-0519
OTHR DR: BENIS,INES N
BUBEN,MICHAEL C

ORDERED: ABG
QUERIES: DELIVERY SYSTEM? VENTILATOR
VENTS: FIO2/VT/RATE/PEEP? 70/550/18/5
WHAT IS THE PATIENTS BODY TEMPERATURE? 98.5

Test	Result	Flag	Reference
Arterial Blood Gases			
pH, Arterial	[redacted]	L	7.35-7.45
PCO2	[redacted]		32-45 mmHg
PO2	[redacted]	H	75-100 mmHg
Bicarbonate	[redacted]	L	18-28 mEq/L
Oxygen Delivery	VENT		
FIO2/VT/Rate?	70/550/18/5		

** END OF REPORT **

RUN DATE: 02/09/11 Grays Harbor Laboratory PAGE 1
RUN TIME: 0110 SPECIAL BROADCAST
RUN USER: LABBKGJOB

Name: 2 - Healthcare Information Readi... Age/Sex: 90/M Attend Dr: BUCK,JULIE M
Acct#: G0133211??? Unit#: M0102440 Status: REG ER Location: ER ED 05
Reg: 02/09/11 Disch:

SPEC #: 0209:U00001S COLL: 02/09/11-0045 STATUS: COMP REQ #: 01226825
RECD: 02/09/11-0052 SUBM DR: BUCK,JULIE M

ENTERED: 02/09/11-0047 OTHR DR: BUBEN,MICHAEL C
ORDERED: UA WITH MICROS
COMMENTS: ANTIBIOTIC THERAPY? UNKNOWN
QUERIES: METHOD OF COLLECTION? STRAIGHT CATHETER
CULTURE IF INDICATED? Y

Test	Result	Flag	Reference
Urinalysis with Microscopic			
Urinalysis			
Collection Method	STCATH		
Color	STRAW		
Appearance	HAZY		
Specific Gravity	1.020		1.003-1.030
pH	5.0		5.0-8.0
Leukocyte Esterase	1+	Ab	NEGATIVE
Nitrite	NEGATIVE		NEGATIVE
Protein Screen	TRACE	Ab	NEGATIVE
Glucose Screen	NEGATIVE		NEGATIVE mg/dL
Ketones	NEGATIVE		NEGATIVE
Urobilinogen	NORMAL		NORMAL-1 mg/dL
Bilirubin Screen	NEGATIVE		NEGATIVE
Occult Blood	NEGATIVE		NEGATIVE
Microscopic			
White Blood Cells	1-5		/hpf
Red Blood Cells	NONE SEEN		/hpf
Epithelial Cells	RARE		/hpf
Bacteria	MODERATE		
Mucous	NONE SEEN		
Culture Criteria Met?	YES		

** END OF REPORT **

RUN DATE: 02/09/11
RUN TIME: 0116
RUN USER: LABBKGJOB

Grays Harbor Laboratory
SPECIAL BROADCAST

PAGE 1

Name: 2 - Healthcare Information Read... Age/Sex: 90/M Attend Dr: BUCK,JULIE M
Acct#: G01332137 Unit#: M0102440 Status: REG ER Location: ER ED-05
Reg: 02/09/11 Disch:

SPEC #: 0208:H00099S COLL: 02/08/11-2354 STATUS: COMP REQ #: 01226825
RECD: 02/09/11-0051 SUBM DR: BUCK,JULIE M

ENTERED: 02/09/11-0047 OTHR DR: BUBEN,MICHAEL C
ORDERED: CBCD, DIFF AND MORPH
QUERIES: Medical Necessity: NA

Test	Result	Flag	Reference
Comp Blood Count/Differential			
Complete Blood Count			
White Blood Cell Count	[redacted]	H	4.8-10.8 thou/uL
Red Blood Cell Count	4.28		4.11-5.74 mill/uL
Hemoglobin	13.5		12.8-17.1 g/dL
Hematocrit	41.0		37.6-50.0 %
Mean Corpuscular Volume	95.9		80.0-98.0 fL
Mean Corpuscular Hemoglobin	[redacted]	H	27.0-31 pg
Mean Cell Hemoglobin Conc	33.0		32.0-36.0 g/dL
Red Cell Distribution Width	14.3		11.5-14.5 %
Platelets	238	D	150-400 thou/uL
Delta: *147 on 06/21/10-0517*			
Mean Platelet Volume	9.1		7.4-10.4 fL
Differential and Morph MANUAL			
Segmented Neutrophils	[redacted]	H	34-64 %
Band Neutrophils	9		5-11 %
Lymphocytes, Normal	[redacted]	L	23-44 %
Monocytes	[redacted]	L	3-6 %
Absolute Neutrophil (calc)	[redacted]	H	1.80-7.70 thou/uL
Platelet Estimate	ADEQUATE		
RBC Morphology	NORMOCYTIC		
RBC Stain Characteristics	NORMOCHROMIC		

** END OF REPORT **

RUN DATE: 02/09/11
RUN TIME: 0117
RUN USER: LABBKGJOB

Grays Harbor Laboratory
SPECIAL BROADCAST

PAGE 1

Name: [redacted] Age/Sex: 90/M Attend Dr: BUCK,JULIE M
Acct#: G0133213777 Unit#: M0102440 Status: REQ ER Location: ER ED-05
Reg: 02/09/11 Diach:

SPEC #: 0208:C00109S COLL: 02/08/11-2354 STATUS: COMP REQ #: 01226825
RECD: 02/09/11-0051 SUBM DR: BUCK,JULIE M

ENTERED: 02/09/11-0047 OTHR DR: BUBEN,MICHAEL C
ORDERED: METABOLIC PANEL, MG, CK, TROP T, ALC
COMMENTS: Medical Necessity: NA
QUERIES: Medical Necessity: NA

Test	Result	Flag	Reference
Comprehensive Metabolic Panel			
Sodium	141		136-145 mEq/L
Potassium	5.2	H	3.5-5.1 mEq/L
Chloride	111	H	96-107 mEq/L
Bicarbonate	23		22-31 mEq/L
Anion Gap	12		7-18
Glucose Random	121	H	60-121 mg/dL
Urea Nitrogen	40.0	H	8.0-23.0 mg/dL
Creatinine	1.2		0.7-1.2 mg/dL
GFR Est Non-African American	59	L	SEE NOTE SEE NOTE
Reference range for eGFR is >59mL/min/1.73sq.meters.			
This result is for non-African Americans. If patient is African American, multiply by 1.21 for correct estimate.			
Magnesium	2.2		1.6-2.4 mg/dL
Calcium	9.0		8.2-9.6 mg/dL
Albumin Adjusted Calcium	9.1		mg/dL
Protein Total	6.5		6.4-8.3 g/dL
For recumbent patients: 6.0 - 7.8 is "normal."			
Patients >60y may run about 0.2g lower.			
Albumin	3.9		3.4-4.8 g/dL
Albumin/Globulin Ratio	1.5		1.1-1.8
Bilirubin Total	0.1	L	0.2-0.9 mg/dL
Alanine Aminotransferase	15		10-44 U/L
Alkaline Phosphatase	105		40-129 UL
Aspartate Aminotransferase	21		10-34 U/L
Creatine Kinase	28		20-200 U/L
Troponin I	< 0.01		0.00-0.03 ng/mL
Alcohol Serum	< 0.01		<0.01 gm/dL
Values up to 0.050 gm/dL are not indicative of alcohol intoxication.			

** END OF REPORT **

Pt re-eval- hypertensive, tachy, O2 87% on RA
- little response to sternal rub, pinpoint pupils
- Woke to Narcan - drip started pupils reactive

NEURO
__abnml serial 7's / inattentive / memory loss
__disoriented to time / place / person
higher functions
__abnml response to commands
no response eyes open slow inappropriate
__cognition nml
__oriented x3
__abnml response to pain
withdraws flexor extensor none
__no evidence of acute CVA
__dysarthria / aphasic expressive receptive
cranial nerves-
__facial palsy *forehead involved spared*
__nml as tested
__tongue deviation (to R / L)
cerebellar-
__abnml Romberg / gait / finger-nose test
__nml as tested
__abnml gait / ataxia
sensorimotor-
__weakness / hemiplegia / dysprazia
__sensation nml
s Narcan - equal grips
__motor nml
__pronator drift
__reflexes nml
__altered light-touch / pin-prick / 2-pt discrimin
__tremor / abnml movements
__Babinski reflex
__asterixis

PSYCH
__disheveled / poor eye contact
mental status
__increase / decrease psychomotor
__appearance nml
__depressed / tearful / anxious / paranoid
__kinetics nml
__labile / flat / agitated
__mood / affect nml
__non-communicative / pressured / slow
__speech nml
__rambling / tangential slurred & dentals
__thought content nml
__suicidal / homicidal ideation / plan
__grandiosity / hallucinations vis / aud
__thought process nml
__thought blocking / loose associations
__disorganized / flight of ideas
__judgment / insight
__poor insight / poor judgment

HEENT
__tenderness / swelling / ecchymosis
__head atraumatic
__raccoon eyes / Battle's sign
__PERRL 3 - reactive
__scleral icterus / pale conjunctivae
__visual fields nml
__unequal pupils R ____mm L ____mm
__EOM's intact
__abnml funduscopic / papilledema
__ENT inspection nml
__EOM palsy / nystagmus
__oropharynx nml
__TM blood
__deprsd gag reflex / handles secretions poorly
__dry membranes
__pharyngeal erythema / dental decay / exudate

NECK
__cervical lymphadenopathy
__supple
__stiff neck / meningismus
__non-tender
__carotid bruit
__Kernig's sign / Brudzinski's sign

RESPIRATORY
__respiratory distress
__no resp. distress
__wheezes / rales (rhonchi) occas
__breath sounds nml

CVS
__tachycardia / bradycardia / irreg. irreg. rhythm
__JVD present
__reg. rate & rhythm
__murmur *grade* ___/6 *sys / dias*
__heart sounds nml
__gallop (S3 / S4)
__decreased pulse(s)

ABDOMEN / GI
__guarding / tenderness
__non-tender
__hepatomegaly / splenomegaly / mass
__no organomegaly
mid line scar

EXTREMITIES
__tenderness
__non tender
__pedal edema
__nml ROM
__Homan's sign
__no pedal edema
(B) AKA

SKIN
__cyanosis / diaphoresis / pallor / ecchymosis
__color nml, no rash
__rash / embolic lesions
__warm, dry
__decubitus

LABS, EKG & XRAYS
**Normal lab value ranges are included on the original lab report*

- pupils reactive

CBC	Chem	AST	PT	UA
nml except	*nml except*	Alk Phos	INR	*nml except*
WBC	Na	Ammonia	PTT	
Hgb	K	TSH	Blood Tox	Preg Test + -
Hct	Gluc	T4	ASA	Urine Tox
platelets	BUN	D-Dimer	APAP	*(circle)*
segs	Creat	Lactate	BAL	cocaine / PCP
bands	HCO3		TCA	amphetamine
				opioids / THC

ABGs FiO_2 ____/RA pH ____ pO2 ____ pCO2 ____
CSF clear xanthochromia bloody prot ____ gluc ____
WBC ____ PMN ____ lymph ____ RBC ____

EKG *interp by ED provider* Rate ____ __NSR __A-fib ____
__nml intervals __nml axis __nml QRS __non-specific ST/TW changes
diagnosis __nml __abnml

CXR *interpreted by ED provider unless noted otherwise*
__nml / NAD __no infiltrates __nml heart size __nml mediastinum
Old CXR- unchanged date:

CT Scan / MRI *brain* ____ *contrast / non-contrast*
nml / NAD

PROGRESS
☐ see additional template: # P4 51a

Time ____ unchanged improved re-examined
PT consistently responds to Narcan bolus - not will maintain on drip
__Poison control consulted
☐ patient ambulating / mentating at pre-event baseline
Discharge VS: BP ____ HR ____ RR ____ Temp ____
__Dr. ____ called at ____ Rec. call ____
will see patient in: ED / hospital / office

Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up
__prior records ordered
☐Rx given

Additional history from:
family caretaker paramedics
__holding orders written

CRITICAL CARE *(excluding time for other separate services)*
TIME ☐ *30-74 min* ☐ *75-104 min* ____ *min*

CLINICAL IMPRESSION

ALTERED MENTAL STATE	Insulin Reaction *Hypoglycemio*
COMA	Meningitis
DELIRIUM	Overdose *Hypnotic / Narcotic*
Alcohol Intoxication	Seizure *post-ictal*
Carbon Monoxide Intoxication	Sepsis
Cerebrovascular Accident	Status Epilepticus *non-convulsive*
Hepatic Encephalopathy	Subarachnoid Hemorrhage
HHNC	Subdural Hematoma
Hypernatremia / Hyponatremia	Uncal Herniation
Intracranial Hemorrhage	

(2) Possible Opiod effects (3) UTI - possible Sepsis SIRS

Present On Admission decubitus / UTI w/ foley

Disposition Order Time ____
DISPOSITION- ☐ home ☐ admitted ☐ OBS ____
☐ AMA *(see AMA template #73)* ☐ transferred ____
Time Completed ____
CONDITION- ☐ unchanged ☐ improved ☐ stable
Care transferred to ____ MD / DO / MLP Time: ____
NP / PA IDX Provider # ____

☐ I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan and disposition.

MD / DO IDX Provider # ____
☐ Template Complete ☐ Dictated Addendum

Altered Mental Status-45

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Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

G013321377

2 - Healthcare Inform...
DOB 2 - Health... M AGE: 90
02/09/11 ER

M0102440

45 **Altered Mental Status**

Sepsis / HHNC / Seizure / ICH / CO / CVA

DATE: 2/9 TIME: 0040 Dr.: Budd EMS Arrival

HISTORIAN: patient family EMS NH records

AGE 90 (M) F

UNABLE TO obtain HISTORY DUE TO: pt's wax waning MS

CC - feels "runny"

HPI

chief complaint: decreased mental status / confusion
low blood sugar / diaheric fever

onset / duration: tonight
per son; normal at dinner
upon waking cannot confirm onset
gone now better continues in ED more than 3 hours
gradual-onset
sudden-onset
intermittent
constant

character of altered mental status:
disoriented / confused / combative / agitated / trouble concentrating
unresponsive / seizure activity / decreased responsiveness

context:
found unresponsive / unknown duration
by nursing home staff bystander family:
dextrostick PTA (250) given D50 / Narcan PTA
good / marginal / no response
recent / heavy alcohol intake (beer / wine / liquor)
last drink
drug abuse / overdose
trauma head injury
infection / other ill contacts unknown

baseline

Cognitive:
alert, oriented x3
alert but disoriented
alert but confused
poor alertness
memory loss

Gait:
walks w/o assistance
uses a cane / walker
walks only w/ assistance
stands for transfers
unable to walk

associated symptoms:
fever / chills / sweaty
chest pain
neck / back pain
hurts to breathe / short of breath
headache
new weakness
RUE RLE LUE LLE
R/L facial generol (diffuse)
altered sensation
RUE RLE LUE LLE R/L facial
falling injury
decreased ability to stand / walk
weak difficult off balance
cannot walk cannot stand
fainting / dizzy
involuntary seizure / movements

Similar symptoms previously

Recently seen / treated by doctor

ROS - when awake, felt well at last time

CONST NO HA/N/V
recent illness
EYES / ENT
vision change / problems
sore throat / dental problems
trouble swallowing
CVS / PULMONARY
palpitations
cough bloody / productive
GI / GU
nausea / vomiting
abdominal pain
diarrhea / black / bloody stool
problems urinating limited by LOC
FEMALE GENITAL
LNMP preg post-menop
MS / SKIN / LYMPH
joint pain
leg / ankle swelling
rash
swollen glands
NEURO (see HPI) / PSYCH
depression / anxiety
all systems neg except as marked

PAST HX GERD/PUD/gastritis

RELATED PAST HX
confusion / dementia
CVA / TIA bleed deficit
diabetes Type 1 Type 2
diet / oral / insulin neuropathy
hepatitis / cirrhosis
overdose
seizure disorder
old records reviewed / summary:
BPH PUD anemia
WBC 6.1
cardiac disease
angina MI CHF
GI bleeding
hyperlipidemia
hypertension
immunosuppressed AIDS
insect bite
lung disease asthma COPD

Surgeries / Procedures none
(B) AKA
any recent surgery
appendectomy
CABG
cholecystectomy
hysterectomy / BTL / C-section
pacemaker
tonsillectomy
Imaging previous CT / MRI / US date
Immunization UTD

Medications none see nurses note
ASA clopidogrel warfarin LMWH
NSAID acetaminophen narcotic chronic
new medications

Allergies NKDA
see nurses note
antibiotic

SOCIAL HX smoker drugs
alcohol (recent / heavy / occasional) occupation
living situation alone family friend group care facility c wife

FAMILY HX stroke migraines CAD HTN

Nursing Assessment Reviewed Initial Vital Signs Reviewed Telemetry
BP 127/75 HR 101 RR 14 Temp 96
Pulse Ox 92 % RA O2 interp nml hypoxic

PHYSICAL EXAM
EXAM LIMITED BY:
General Appearance mild / moderate / severe distress
appears well lethargic / obtunded / combative
alert aphasic
airway intact

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PROVIDER RECORD

G013321377

DOB 02/09/11 ER AGE: 90

M0102440

M.EDMDTS

ER 724-045 Rev. 07/09 Pg 1 of 2

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MD 2011-153821-000061

Grays Harbor PATIENT CARE INQUIRY *LIVE*
Summary of Laboratory Tests

2 - Healthcare Information Rea... (M0102440) TOXICOLOGY
Age/Sex: 90 M
Room CCU 300 05 (Admitted Feb 09, 11)

Test	Result	Flag	Date	Time	Timeline of Results
					Jan 25, 2011 — 16 Days — Feb 09, 2011
					25 26 27 28 29 30 31 01 02 03 04 05 06 07 08 09
TOXICOLOGY					
[TOX]	Complete		Feb 09	00:45	Complete
Drug Cut-offs	->	<C>	Feb 09	00:45	SEE BELOW
Amphetamines	->		Feb 09	00:45	NEGATIVE
Methamphetamine	->		Feb 09	00:45	NEGATIVE
Barbiturates	->		Feb 09	00:45	NEGATIVE
Benzodiazepines	->		Feb 09	00:45	NEGATIVE
Cocaine Metab	->		Feb 09	00:45	NEGATIVE
Methadone	NEGATIVE		Feb 09	00:45	NEGATIVE
Opiates	NEGATIVE		Feb 09	00:45	NEGATIVE
Phencyclidine	->		Feb 09	00:45	NEGATIVE
THC (Marijuana)	->		Feb 09	00:45	NEGATIVE
Tricycl Antidep	->		Feb 09	00:45	NEGATIVE
Oxycodone	POSITIVE	CAb	Feb 09	00:45	POSITIVE

Run: Wed - Feb 09 (05:26) for WHISENHUNT, ROY H

RUN DATE: 02/09/11 Grays Harbor Laboratory PAGE 4
RUN TIME: 0718 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: KGRENON PCI User: KGRENON Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Rea... #G01321377 (Continued)

**********URINALYSIS**********

Date	2/9/11		
Time	0045	Reference	Units
Collection	STCATH		
Color	STRAW		
Appearance	HAZY		
Spec. Gravity	1.020	[1.003-1.030]	
pH Urine	5.0	[5.0-8.0]	
Leuk. esterase	2+ Abn	[NEGATIVE]	
Nitrite	NEGATIVE	[NEGATIVE]	
Protein Screen	TRACE Abn	[NEGATIVE]	
Glucose Screen	NEGATIVE	[NEGATIVE]	mg/dL
Ketones	NEGATIVE	[NEGATIVE]	
Urobilinogen	NORMAL	[NORMAL-1]	mg/dL
Bilirubin Scrn	NEGATIVE	[NEGATIVE]	
Occult Blood	NEGATIVE	[NEGATIVE]	
White Bld Cells	1-5		/hpf
Red Blood Cells	NONE SEEN		/hpf
Epithelial Cell	RARE		/hpf
Bacteria	MODERATE		
Mucous	NONE SEEN		
Cult Indicated?	YES		

Test	Day	Date	Time	Result	Reference	Units
Drug Cut-offs	1	FEB 9	0045	SEE BELOW(e)		
Amphetamines	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Methamphetamine	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Barbiturates	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Benzodiazepines	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Cocaine Metab	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Methadone	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Opiates	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Phencyclidine	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
THC (Marijuana)	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Tricycl Antidep	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	

NOTES: (e) The following cut-off concentrations are established for the drug classes screened:

AMP	Amphetamines	1000	ng/mL
mAMP	Methamphetamines	1000	ng/mL
BAR	Barbituates	300	ng/mL
BZO	Benzodiazepines	300	ng/mL
COC	Cocaine	300	ng/mL
MTD	Methodone	300	ng/mL
PCP	Phencyclidine	25	ng/mL
THC	Marijuana Metabolites	50	ng/mL
TCA	Tricyclic Antidepressants	1000	ng/mL
OXY	Oxycodone	100	ng/mL

Patient: 2 - Healthcare Information Re... Age/Sex: 90/M Acct#G01321377 Unit#M0102440

RUN DATE: 02/09/11
RUN TIME: 0718
RUN USER: KGRENON

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: KGRENON Lab Database: LAB.GRY

PAGE 1

PATIENT: [redacted] ACCT #: G013321377 LOC: CCU U.#: M0102440
AGE/SEX: 90/M ROOM: 300 REG: 02/09/11
REG DR: BENIS,INES N STATUS: ADM IN BED: 05 DIS:

**********CHEMISTRY**********

	Date	2/9/11	2/8/11			
	Time	0040	2354		Reference	Units
Sodium			141		[136-145]	mEq/L
Potassium			5.2	H	[3.5-5.1]	mEq/L
Chloride			111	H	[96-107]	mEq/L
Bicarbonate			23		[22-31]	mEq/L
Anion Gap			12		[7-18]	
Glucose Random			291	H	[60-121]	mg/dL
Urea Nitrogen			40.0	H	[8.0-23.0]	mg/dL
Creatinine			1.2		[0.7-1.2]	mg/dL
GFR Est NonAfr			57(a)	L	[SEE NOTE]	SEE NOTE
Ammonia		60			[27-102]	ug/dL
Magnesium			2.2		[1.6-2.4]	mg/dL
Calcium			9.0		[8.2-9.6]	mg/dL
Alb adj Calcium			9.1			mg/dL
Total Protein			6.5(b)		[6.4-8.3]	g/dL
Albumin			3.9		[3.4-4.8]	g/dL
A/G Ratio			1.5		[1-1.8]	
Bilirubin Total			0.1	L	[0.2-0.9]	mg/dL
ALT			15		[10-44]	U/L
Alk Phosphatase			105		[40-129]	U/L
AST			21		[10-34]	U/L
Creatine Kinase			28		[20-200]	U/L
Troponin T			< 0.01		[0.00-0.03]	ng/mL
Alcohol,Serum			<0.01(c)		[<0.01]	gm/dL

NOTES: (a) Reference range for eGFR is >59mL/min/1.73sq.meters.
This result is for non-African Americans. If patient is African-American, multiply by 1.21 for correct estimate.
(b) For recumbent patients: 6.0 - 7.8 is "normal."
Patients >60y may run about 0.2g lower.
(c) Values up to 0.050 gm/dL are not indicative of alcohol intoxication.

RUN DATE: 02/09/11 Grays Harbor Laboratory PAGE 3
RUN TIME: 0718 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: KGRENON PCI User: KGRENON Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Re... #G01322377 (Continued)

**********HEMATOLOGY**********

	Date 2/8/11 Time 2354		Reference	Units
WBC	16.1	H	[4.8-10.8]	thou/uL
RBC	4.28		[4.11-5.74]	mill/uL
Hemoglobin	13.5		[12.8-17.1]	g/dL
Hematocrit	41.0		[37.6-50.0]	%
MCV	95.9		[80.0-98.0]	fL
MCH	31.6	H	[27.0-31]	pg
MCHC	33.0		[32.0-36.0]	g/dL
RDW (aniso)	14.3		[11.5-14.5]	%
Platelets	238	D	[150-400]	thou/uL
MPV	9.1		[7.4-10.4]	fL
Polys	79	H	[34-64]	%
Bands	9		[5-11]	%
Lymphs Normal	11	L	[23-44]	%
Monocytes	1	L	[3-6]	%
Abs Neut (calc)	14.17	H	[1.80-7.70]	thou/uL
Plt. Estimate	ADEQUATE			
Seg Neut(calc)	12.7	H	[1.8-7.0]	thou/uL
Band Neut(calc)	1.4	H	[0.0-1.0]	thou/uL
Lymphocyt(calc)	1.8		[1.0-4.8]	thou/uL
Monocytes(calc)	0.2		[0.0-0.8]	thou/uL
RBC Morphology	NORMOCYTIC			
RBC Stain	NORMOCHROMIC			

COAGULATION

	Date 2/8/11 Time 2354		Reference	Units
Protime	13.1		[11.3-14.6]	sec
INR	1.03(d)			
APTT	32		[23-37]	sec

NOTES: (d) INR therapeutic range: 2.0-3.0
Prosthetic valves & recurrent systemic embolism: 3.0-4.5
WARNING: Heparin within last 2 hours of collection may cause a false elevation. (Not a problem with low-molecular weight heparins.)

Patient: 2 - Healthcare Information ... Age/Sex: 90/M Acct#G01322377 Unit#M0102440

51a **Procedures / Critical Care Add-on**

PROCEDURAL SEDATION NOTE

☐ See Nursing notes for V/S monitoring

Sedation type: deep moderate other_____

HPI ☐ see patient template

Indications: _____

last meal _____ Time: _ _ _ _

Past Hx ☐ see patient's template

prior complications to general anesthesia_____

prior complications to procedural sedation_____

Allergies _NKDA see nurses note _____

brevital etomidate fentanyl ketamine lidocaine

midazolam morphine nitrous oxide propofol_____

other_____

ASA Classification _____

E. Emergent conditions applies

P1. Normal healthy patient

P2. Patient with a mild systemic disease

P3. Patient with a severe systemic disease

P4. Patient with a severe systemic disease that is a constant threat to life

P5. Moribund patient who is not expected to survive w/o the operation

Physical Exam ☐ see patient's template

AIRWAY

__nml anatomy

__obese

__large tongue / teeth

__angioedema

__abnormal rule 3-3-2 rule

__possible upper airway obstruction

__neck immobility

Mallampati Classification _____

Class1. Soft palate, anterior / posterior tonsillar pillars, and uvula visible

Class2. Tonsillar pillars and uvula hidden by base of tongue

Class3. Only soft palate visible

Class4. Soft palate not visible

Preparation

__plan explained: _____

to patient to parent / guardian

__consent signed (see hospital content)_____

__oximetry during procedure_____

__capnometry during procedure_____

__IV access obtained_____

__suction immediately available_____

__cardiac monitor used_____

Sedation

__versed_____

__etomidate_____

__propofol_____

__fentanyl_____

__ketamine_____

Reversal

__none_____

__narcan_____

__romazicon_____

Complications during / after procedure- none vomiting apnea O_2 desaturation required BVM-PPV hypotension agitation other_____

Post Sedation Recovery Score ☐ see sedation record

I personally performed ☐ sedation and / or ☐ procedure

Intra-service time: __30 min or less __31-45 min __46-60 min

INTUBATION NOTE - Supervised Medic for intub

Airway Evaluation abnormal 3-3-2 rule obese large tongue large / loose teeth copious secretions Mallampati Class: 1 2 3 4 5

Pre-tx __100% O_2 other_____

Induction __etomidate ✓midazolam __propofol other:_____

Paralysis ☐ no contraindications to succinylcholine

✓rocuronium __succinylcholine K=5.2

other_____

Equipment ✓ETT / LMA size _____

__Glidescope / McGrath __Bougie_____

other_____

Post-intubation management: after ETT passed pt vomited prior to balloon inflation

ETT primary tube confirmation

__capnometry ___mm Hg ✓CO_2 change

__direct visualization ✓chest rise

__tube in good position on CXR

__tube repositioned and re-confirmed with CXR

Vent settings: ☒ per Respiratory Therapy

Mode: CMV AC SIMV PS CPAP_____

Settings: TV 550 FIO_2 100 R 18 PS____ PEEP____

Ventilator sedation: propofol drip / other_____ - family aware of possible aspiration

Additional Notes: _____

Pt woke c repeated doses of Norcuron. Attgon's req, pt asked if he wanted intub for life saving and completion reversible - pt clearly stated in front of family he wanted intubation if reversible.

CENTRAL LINE

__CDC Sterile insertion guidelines followed_____

__2% chlorhexidine prep_____

__local anesthetic *lidocaine 1% / 2%* ____mL_____

bupivacaine 0.25% / 0.5% ____mL_____

catheter_____Fr *single / triple lumen PreSep*_____

location: R / L *U/S guided IJ subclavian supraclavicular supraclavicular brachial femoral*_____

complications: none_____

CXR post-procedure:_____

TIME OUT called at: _ _ _ _ for_____

TIME OUT called at: _ _ _ _ for_____

TIME OUT called at: _ _ _ _ for_____

_____ *NP / PA IDX Provider #*_____

_____ *MD / DO IDX Provider #*_____

☐ Template Complete ☐ Dictated Addendum

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

ER 724-51a Rev. 07 / 09 Pg 1 of 2

G013321377

DOB [redacted] M AGE: 90

02/09/11 ER

M0102440

TIME:	DATE:	
	ORDERS	**RESULTS**
	☐ FHT	BPM _____ ____ (init)
	☐ Orthostatic VS _____	
		Supine BP _____ P _____ ____ (init)
		Sit BP _____ P _____ ____ (init)
		Stand BP _____ P _____ ____ (init)
	☐ Fingerstick Glucose _____	____ mg/dl
	☐ Visual Acuity:	OS ___ OU ___ OD ___ ____ (init)
	☐ Urine Pregnancy _____	+ - _____ ____ (init)
	☐ Urine Dip (Refer to urine slip)	____ (init)
	☐ Gastroccult + - _____	_____
	☐ Hemoccult + - _____	_____ ____ (init)
	☐ ISTAT ☐ TROPT ☐ ABG ☐ CHEM 8	____ (init)
0250	Narcan 0.4 mg IVP x1 - late entry	Dunoff
	Narcan drip - start @ 0.4 mg/hr - titrate to reusable airway, MAP >60, sat >92% on 2L RR >10	
	Ceftriaxone 1g IV x1 ✓	
0350	NS 500 ml IV x1 ✓	
0410	~~Unasyn 3.375 g IV x1~~ ✓ error JB	
0415	2o Syn 3.375 g IV x1	
	Allergies: Bactrim / Clindamycin	
	Physician / Mid-Level Signature:	

Grays Harbor COMMUNITY HOSPITAL
Aberdeen, WA 98520

M.EDMDORD

Emergency Dept.

Physician Orders

ER723-502 (11/02/10)

PATIENT LABEL

G013321377

2 - Healthcare Inform...

DOB 2 - Health... M AGE: 90

02/09/11 ER

M0102440

Bowel Record		01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informat... (9713600)
Facility	Montesano Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Paylaes Pharmacy	Diet	NAS. - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS			
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)			
Advanced Directive										

Schedule for February 2011	Hours	T 1	W 2	T 3	F 4	S 5	S 6	M 7	T 8	W 9	T 10	F 11	S 12	S 13	M 14	T 15	W 16	T 17	F 18	S 19	S 20	M 21	T 22	W 23	T 24	F 25	S 26	S 27	M 28
(1) RES. WITH NO BM BY 9TH SHIFT WILL HAVE BOWEL PROGRAM STARTED. DOCUMENT SIZE OF STOOLS QS ON BOWEL MONITORING. SM= SMALL, MED= MEDIUM, LG= LARGE, XL= EXTRA LARGE, D= LOOSE/DIARRHEA. - - DOCBM Start Date: 6/28/2010	NOC																												
	SIZE	S	S					L	M																				
	DAY																												
	SIZE					L	M	L	M																				
	EVE																												
	SIZE	L	L																										
(4) IF NO RESULTS FROM DULCOLAX TAB, RES TO RECIEVE DULCOLAX SUPPOSITORY 10mg RC. - - PRN1 Start Date: 6/28/2010	PRN																												
(5) IF NO RESULTS FROM OULCOLAX SUPPOSITORY, GIVE FLEETS ENEMA 1 RC, IF ORDERED. - - PRN1 Start Date: 6/28/2010	PRN																												
(6) IF NO RESULTS FROM FLEETS ENEMA, CALL MD FOR FURTHER ORDERS - - PRN1 Start Date: 6/28/2010	PRN																												
(2) BEGINNING OF 9TH SHIFT RES TO RECEIVE 30cc MOM PO UNLESS DIALYSIS PATIENT - - PRN2 Start Date: 6/28/2010	PRN																												
	PRN																												
(3) IF NO RESULTS FROM MOM RES TO RECIEVE ORAL LAXATIVE OULCOLAX 5mg EC TAB PO. - - PRN2 Start Date: 6/28/2010	PRN																												
	PRN																												

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
3 = Absent from home	8 = Nauseated/Vomiting	KP	KPaneda RN		2			Checked By 1st		
1 = Away from home with meds	9 = Other / See Nurse Notes									
2 = Drug Refused	4 = Pulse below 60/min							Checked By 2nd		
5 = Hold/See Nurse Notes	10 = Resident spit out									
6 = Hospitalized	7 = Sleeping							Checked By 3rd		

Medication Administration Record			01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informati... (9713600)
Facility	Montosano Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Payless Pharmacy	Diet	NAS. - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS				
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)				
Advanced Directive											

Schedule for February 2011	Hours	T 1	W 2	T 3	F 4	S 5	S 6	M 7	T 8	W 9	T 10	F 11	S 12	S 13	M 14	T 15	W 16	T 17	F 18	S 19	S 20	M 21	T 22	W 23	T 24	F 25	S 26	S 27	M 28
NORVASC 5 MG PO QD - HOLD IF SBP < 95 - - By mouth (PO) QDBP HTN Start Date: 6/21/2010	0800	RD	|||	|||	|||	RD																			
	B/P	125	128	128	118	128	128	162	180																				
		63	60	62	54	62	64	92	88																				
	P	68	68	68	72	64	72	84	74																				
DIOVAN 80 MG PO QD - HOLD IF SBP < 95 - - By mouth (PO) QDBP HTN Start Date: 6/21/2010	0800	RD	|||	|||	|||	RD																			
	B/P	125	128	128	118	128	128	162	180																				
		63	60	62	54	62	64	92	88																				
	P	68	68	68	72	64	72	84	74																				
DIET AS ORDERED BY RO - - Other INFO Start Date: 6/21/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ALL APPROPRIATE MEDICATIONS MAY BE CRUSHED - - Other INFO Start Date: 6/21/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FINASTERIDE 5 MG PO QD - (PREGNANT WOMEN SHOULD NOT HANDEL PROSCAR) - - By mouth (PO) 0800 BPH Start Date: 6/21/2010	0800	RD	|||	|||	|||	RD																			
VIT C 500 MG PO QD - - By mouth (PO) 0800 SUPPLEMENT Start Date: 6/21/2010	0800	RD	|||	|||	|||	RD																			

C/AS

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
3 = Absent from home 1 = Away from home with meds 2 = Drug Refused 5 = Hold/See Nurse Notes 6 = Hospitalized	6 = Nauseated/Vomiting 9 = Other / See Nurse Notes 4 = Pulse below 60/min 10 = Resident spit out 7 = Sleeping	RT	Tawny Gaston LPN		RK	RK Knoll LPN		Checked By 1st		
								Checked By 2nd		
								Checked By 3rd		

Medication Administration Record			01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informat...	(9713600)
Facility	Montesano Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Payless Pharmacy	Diet	NAS, - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS					
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.8); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)					
Advanced Directive												

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MVI W/ MIN 1 PO QD - - By mouth (PO) 0800 SUPPLEMENT Start Date: 6/21/2010	0800	RK							RK																				
IRON SULFATE 326 MG PO QD - - By mouth (PO) 0800 SUPPLEMENT Start Date: 6/21/2010	0800	RK							RK																				
KCL 10 mEq PO QD - - QD HYPOKALEMIA Start Date: 6/21/2010	0800	RK							RK																				
FLOMAX 0.4 MG PO QD - - By mouth (PO) QD BPH Start Date: 7/17/2010	0800	RK							RK																				
OMEPRAZOLE 20 MG 2 CAPS PO BID - - By mouth (PO) BID GERD Start Date: 6/21/2010	0800	RK							RK																				
	1700	LS	RK	RK		RK	RK		RK																				
CARAFATE 1gm PO BID - SEPERATE ADMINISTRATION BY 2 HRS FROM OTHER MEDS PER PHARMACY RECS. - - By mouth (PO) BID GASTRITIS Start Date: 8/11/2010	1000	RK							RK																				
	2000	LS	RK	RK		RK	RK		RK																				
REQUIP 1 MG PO QHS - - By mouth (PO) HS RESTLESS LEG Start Date: 6/21/2010	2000	LS	RK	RK		RK	RK		RK																				

Chart Codes		Int	Name Signature	Int	Name Signature		Name Signature
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Advanced Directive											

Schedule for February 2011	Hours	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M		
		1	2	3	4	5	6	7	8	0	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28		
HOUSE ANTACID 30CCS PO Q 4 HRS PRN GI UPSET. - - By mouth (PO) prn GI UPSET *Start Date: 6/21/2010*	PRN																														
	PRN																														
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	PRN																														
OCEAN MIST NASAL SPRAY 1 SPRAY EACH NOSTRIL PRN DRYNESS/IRRITATION - - PRN NASAL DRYNESS/IRRITATION Start Date: 10/30/2010	P																														
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LYTES Q 6 MONTHS (JUNE) - ON KCL SUPPLEMENT INFO Start Date: 6/21/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
SEPERATE IRON & CALCIUM DOSES BY 2 HOURS R/T DECREAESED ABSORPTION - - INFO Start Date: 6/21/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
CBC Q 6 MONTHS & IRON STUDIES - 5/2011 - ANEMIA/IRON USE INFO Start Date: 6/30/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
B = Absent from home	6 = Nauseated/Vomiting									
1 = Away from home with meds	9 = Other / See Nurse Notes							Checked By 1st		
2 = Drug Refused	4 = Pulse below 60/min							Checked By 2nd		
5 = Hold/See Nurse Notes	10 = Resident spit out									
8 = Hospitalized	7 = Sleeping							Checked By 3rd		

Medication Administration Record			01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informat... (9713600)
Facility	Monteseno Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Paylass Pharmacy	Diet	NAS. - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS				
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)				
Advanced Directive											

Schedule for February 2011	Hours	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28		
WEIGH Q MONTH - DOC ON MAR & WEIGHT SHEET - - Othor QMONTH Start Date: 9/8/2010	MONTHLY	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	WT																														
VITAL SIGNS Q MONTH - - 1XMBP Start Date: 6/21/2010	1XM	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	INIT	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	B/P	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
		X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	P	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
3 = Absent from home	6 = Nauseated/Vomiting									
1 = Away from home with meds	9 = Other / See Nurse Notes							Checked By 1st		
2 = Drug Refused	4 = Pulse below 60/min									
5 = Hold/See Nurse Notes	10 = Resident spit out							Checked By 2nd		
8 = Hospitalized	7 = Sleeping									
								Checked By 3rd		

Pain Monitor Record			01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informati...	(9713600)
Facility	Montessano Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Poyless Pharmacy	Diet	NAS. - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS					
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)					
Advanced Directive												

Schedule for February 2011	Hours	T 1	W 2	T 3	F 4	S 5	S 6	M 7	T 8	W 9	T 10	F 11	S 12	S 13	M 14	T 15	W 16	T 17	F 18	S 19	S 20	M 21	T 22	W 23	T 24	F 25	S 26	S 27	M 28
MONITOR FOR PAIN QS (+)YES / (-) NO - - Other EACH SHIFT +/- Start Date: 6/21/2010	NOC																												
	+/-																												
	DAY																												
	+/-																												
	EVE	LS	RK	RK		RK	RK		RK																				
	+/-																												
APAP 650 MG PO/PR Q 4 HRS PRN MILD GENERALIZED PAIN AND/OR PAIN/FEVER TEMPERATURE ABOVE 100 DEGREES, NTE 4GMS ACETAMINOPHEN/24 HRS - - PO/PR PRN PAIN/FEVER Start Date: 6/21/2010	PRN																												
	PRN																												
	PRN																												
	PRN																												
DO NOT EXCEED 4000 MG ACETAMINOPHEN/24 HRS - - Other INFO Start Date: 6/21/2010	INFO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
3 = Absent from home 1 = Away from home with meds 2 = Drug Refused 5 = Hold/See Nurse Notes 6 = Hospitalized	8 = Nauseated/Vomiting 9 = Other / See Nurse Notes 4 = Pulse below 60/min 10 = Resident spit out 7 = Sleeping							Checked By 1st		
								Checked By 2nd		
								Checked By 3rd		

Psych			01 February 2011 28 February 2011	DOB Admit Date	29 October 1920 21 June 2010	Room	207	Bed	1	Resident	2 - Healthcare Informat... (9713600)
Facility	Montesano Health and Rehabilitation Center	Physician	BUBEN, MICHAEL	Pharmacy	Payless Pharmacy	Diet	NAS. - Regular - Thin Liquid - *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS				
Allergies	NKA			Medical Conditions	CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6); INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81); CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7); SPASM OF MUSCLE (728.85); UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50); OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99); UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9); LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76); MUSCLE WEAKNESS (GENERALIZED) (728.87); HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00); ESOPHAGEAL REFLUX (530.81)				
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Schedule for February 2011	Hours	T 1	W 2	T 3	F 4	S 5	S 6	M 7	T 8	W 9	T 10	F 11	S 12	S 13	M 14	T 15	W 16	T 17	F 18	S 19	S 20	M 21	T 22	W 23	T 24	F 25	S 26	S 27	M 28
CITALOPRAM 20 MG PO QAM - - By mouth (PO) QD DEPRESSION Start Date: 6/21/2010	0800	LOA	|||	|||	|||	PA																			
MONITOR FOR S/S OF DEPRESSION Q SHIFT; I.E. CHANGE IN EATING/SLEEP, DECREASED SOCIALIZATION - DESCRIBE ON BACK - - EACH SHIFT +/- Start Date: 6/21/2010	NOC																												
	+/-	—	—	—	—	—	—	—	—																				
	DAY	RA	|||	|||	|||	RA																			
	+/-	—	—	—	—	—	—	—	—																				
	EVE	LS	RA	RA		RA	RA		RA																				
	+/-	—	—	—	—	—	—	—	—																				
REMERON 15 MG PO QHS - - By mouth (PO) HS DEPRESSION Start Date: 6/21/2010	2000	LS	RA	RA		RA	RA		RA																				

Chart Codes		Int	Name	Signature	Int	Name	Signature		Name	Signature
3 = Absent from home 1 = Away from home with meds 2 = Drug Refused 5 = Hold/See Nurse Notes 6 = Hospitalized	8 = Nauseated/Vomiting 9 = Other / See Nurse Notes 4 = Pulse below 60/min 10 = Resident spit out 7 = Sleeping							Checked By 1st		
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Blood cultures x2 obtained. Sputum x2 obtained.

Urinalysis: 2+ leukocyte esterase, 1-5 white blood cells; culture pending.

Toxicology screen positive for oxycodone. A repeat was requested and that too was positive for oxycodone.

A head CT without contrast shows small-vessel disease.

Chest x-ray: No focal airspace disease. ET tube placement okay.

EKG: Atrial fibrillation at a rate of 102. Slow R wave progression. Nonspecific ST-T wave changes.

ASSESSMENT AND PLAN

1. Acute respiratory failure, obtunded, encephalopathic, unable to protect airway. This could possibly be secondary to oxycodone toxicity. This, however, was not prescribed and it is unclear exactly how the patient could have received this. A repeat toxicology screen, however, was positive. It certainly could be a real ingestion. It could be a false positive. His condition could also be sepsis secondary to urinary tract infection or possibly pneumonia. Sepsis can occasionally improve with Narcan as well temporarily and his episode was also complicated by hypotension. This could be systemic inflammatory response syndrome or sepsis. No obvious infiltrate. Clinically improved at this time. Long family discussion. We will attempt weaning parameters, hoping to extubate him and will follow sputum cultures carefully.

2. Pyuria. This could also be a urinary tract infection. The patient is on ceftriaxone. Follow cultures. IV hydration.

3. Systemic inflammatory response syndrome, present on admission, now with mild acute renal failure and dehydration. Aggressively hydrate.

4. Depression. Continue medications.

5. Candida of the skin, also suggested by sputum Gram's stain. Fluconazole and nystatin powder to skin folds. Multivitamin, zinc, vitamin C.

6. Gastroesophageal reflux. Continue Protonix.

7. Deep venous thrombosis prophylaxis. Lovenox subcutaneously 30 mg daily.

8. Hyperglycemia. Could be secondary to acute illness response. Check hemoglobin A1c. Sliding-scale insulin.

9. EKG showed atrial fibrillation, which is chronic. Rate controlled. Continue aspirin for cerebrovascular accident prophylaxis. Consider checking an echocardiogram.

IDENTIFICATION
This 90-year-old male presents from Montesano Health and Rehabilitation Center because of the sudden onset of change in mental status. He responded some to Narcan initially and now has decreasing mental status. He was intubated in the emergency department.

HISTORY OF PRESENT ILLNESS
He was in his usual state of fair health, living at Montesano Health and Rehabilitation Center with his wife. His son reports that he saw the patient at lunch and he was in his usual state of health. Then, reportedly, he was found to be obtunded with shallow respirations. He had only moaning. He did wake up for the paramedics briefly after Narcan. At that time, he was transferred to the emergency department.

There, his paperwork showed he was DNR and they contacted the family. The patient was started on a Narcan drip. Because of intubation, he was given empiric ceftriaxone, 1 gram IV, normal saline boluses, and Zosyn 3.375 mg.

It was decided that the patient required intubation due to increasing difficulty protecting his airway. He had hypotension, responding to IV fluids. Upon talking with the family, he told his family that he wanted intubation if it was thought to be reversible, and the decision was made to pursue intubation.

After intubation, part of the workup included a toxicology screen, which was positive for oxycodone. The nursing home was contacted again and there was reportedly no prescribed oxycodone and no obvious thought how the patient could receive oxycodone.

His blood sugar at the time was 253. His family said this was a sudden change in his mental status. He has required intubation at times in the past and has had episodes of urinary tract infections, thought to be secondary to methicillin-resistant Staphylococcus aureus. He has had significant peripheral vascular disease and has been on chronic medications. He has had no fevers, chills, or other complaints.

ALLERGIES
1. BACTRIM.
2. CLINDAMYCIN.

PAST MEDICAL HISTORY
1. Peripheral vascular disease, status post amputation bilaterally above the knee.
2. Hypertension.
3. GERD.
4. Peptic ulcer disease.
5. Hyperlipidemia.
6. BPH.

7. Iron-deficiency anemia.
8. History of GI bleed in 2008.
9. Depression.
10. Chronic atrial fibrillation.

MEDICATIONS
1. Remeron 15 mg p.o. q.h.s.
2. Citalopram 20 mg p.o. daily.
3. Norvasc 5 mg daily.
4. Diovan 80 mg daily.
5. Finasteride 8 mg p.o. daily.
6. Vitamin C 500 mg daily.
7. Multivitamin 1 daily.
8. Iron sulfate 325 mg daily.
9. Flomax 0.4 mg p.o. daily.
10. Omeprazole 20 mg p.o. daily.
11. Carafate 1 gram p.o. b.i.d.
12. Requip 1 mg p.o. q.h.s.

SOCIAL HISTORY
He lives at Montesano Health and Rehabilitation Center. He has a wife. A son and daughter-in-law assist in his care. Nonsmoker. No history of alcohol intake. No recreational drug use.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 136/66, heart rate 64, respiratory rate 18, temperature 97.6, oxygen saturation 100% on the ventilator, 100% FiO2, tidal volume 500, PRVC 18, PEEP 5, pH 7.29, PCO2 28, PO2 207. Weight 54.5 kg.

NECK: No evidence of JVD.

LUNGS: Clear. Decreased in the bases.

HEART: Regular rate and rhythm.

ABDOMEN: Soft, nontender. No hepatosplenomegaly or masses.

EXTREMITIES: No clubbing, cyanosis or edema. As listed above, bilateral above-the-knee amputations.

NEUROLOGIC: Follows some commands. Moves extremities.

DIAGNOSTIC STUDIES
Pertinent lab work includes a sodium of 141, potassium 5.2, chloride 111, bicarbonate 23, BUN 40, creatinine 1.2, and glucose 291. White blood cell count 16.1, increased polys but no bandemia, hematocrit 41, MCV 95.9, platelets 230,000. Magnesium 2.2, bilirubin 0.1, ALT 15, AST 21, alkaline phosphatase 105. Troponin T less than 0.01.

Blood cultures x2 obtained. Sputum x2 obtained.

Urinalysis: 2+ leukocyte esterase, 1-5 white blood cells; culture pending.

Toxicology screen positive for oxycodone. A repeat was requested and that too was positive for oxycodone.

A head CT without contrast shows small-vessel disease.

Chest x-ray: No focal airspace disease. ET tube placement okay.

EKG: Atrial fibrillation at a rate of 102. Slow R wave progression. Nonspecific ST-T wave changes.

ASSESSMENT AND PLAN

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3. Systemic inflammatory response syndrome, present on admission, now with mild acute renal failure and dehydration. Aggressively hydrate.

4. Depression. Continue medications.

5. Candida of the skin, also suggested by sputum Gram's stain. Fluconazole and nystatin powder to skin folds. Multivitamin, zinc, vitamin C.

6. Gastroesophageal reflux. Continue Protonix.

7. Deep venous thrombosis prophylaxis. Lovenox subcutaneously 30 mg daily.

8. Hyperglycemia. Could be secondary to acute illness response. Check hemoglobin A1c. Sliding-scale insulin.

9. EKG showed atrial fibrillation, which is chronic. Rate controlled. Continue aspirin for cerebrovascular accident prophylaxis. Consider checking an echocardiogram.

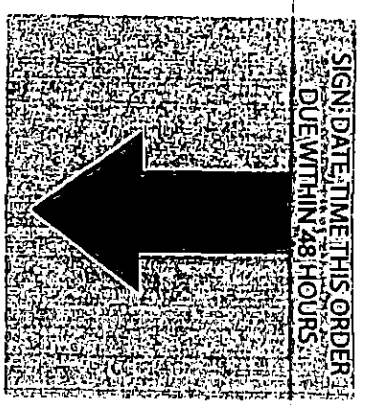
10. Antihypertensives. Hold tonight in a setting of hypotension.

_____

Barbara L. Givens, MD Date/Time

GIVBA/MEM D: 02/13/2011 at 19:02 T: 02/13/2011 at 19:19 J: 10644505 Doc: 20048393

CC: Michael Buben, DO



TTENDING HOSPITALIST:
ıny G. Bashandy, MD

PRIMARY CARE PROVIDER:
Richard D. Lewis, MD

DATE OF ADMISSION:
1/19/2009 at 2345 hours.

CODE STATUS:
Do-not-resuscitate and do-not-intubate.

CHIEF COMPLAINT:
Altered mental status.

HISTORY OF PRESENT ILLNESS:
This 88-year-old skilled nursing facility resident apparently had increased confusion today at Montesano Health and Rehab. He was reported to have difficulty holding objects in his right hand. There was a reported right facial droop that had resolved and resolved right upper extremity weakness for an unspecified period of time. The patient is currently disoriented and provides no further insight into the nature of his problems. He has no specific complaints at this time. There is no specific prior history of a cerebrovascular accident.

PAST MEDICAL HISTORY:
1. Gastroesophageal reflux disease.
2. Previous history of peptic ulcer disease.
3. Hypertension.
4. Hyperlipidemia.
5. Peripheral vascular disease.
6. Benign prostatic hypertrophy.
7. Iron deficiency anemia.
8. Bilateral above-knee-amputation.
9. Upper gastrointestinal bleed, in June of 2008.

Surgeries:
1. Bilateral above-knee-amputation at two different times, both secondary to peripheral vascular disease.
2. Fiberoptic esophagogastroduodenoscopy, in June of 2008, showing gastritis with friable mucosa.

Allergies: No known drug allergies.

Medications:
1. Diovan 80 mg p.o. daily.
2. Norvasc 5 mg p.o. daily.

Finasteride 5 mg p.o. daily.
Flomax 0.4 mg p.o. daily.
Iron sulfate 325 mg p.o. daily.
6. Flonase spray 1 spray daily.
7. Multivitamin daily.
8. Requip 1 mg daily.
9. Protonix 80 mg p.o. b.i.d.
10. Calcium 500 mg with vitamin D p.o. daily.
11. Mylanta 30 mL p.r.n. with meals.
12. Reglan 10 mg p.o. t.i.d.
13. Carafate 1 gm p.o. q.i.d.
14. Citalopram 10 mg p.o. daily.
Remeron 50 mg p.o. h.s.

FAMILY HISTORY:
Noncontributory.

SOCIAL HISTORY:
The patient resides at Montesano Health and Rehab. He is married. He does not currently smoke, drink or use illicit drugs.

REVIEW OF SYSTEMS:
Unable to obtain an accurate review of systems due to confusion.

PHYSICAL EXAMINATION:
VITAL SIGNS ON ADMISSION TO ER: Temperature 98.7, pulse 72, respiratory rate 1[illegible] blood pressure 165/79. SpO2 100% on room air.

GENERAL: No acute distress.

HEENT: Normocephalic, atraumatic. Pupils are equal, round, and reactive to light and accommodation. Arcus senilis present.

NECK: No thyromegaly or lymphadenopathy. No carotid bruits.

LUNGS: Clear to auscultation.

HEART: Irregular at times. No murmur, gallop or rub. No S3, S4.

ABDOMEN: Soft, nontender.

EXTREMITIES: Bilateral amputations above the knee. In both upper extremities, distal pulses intact.

NEUROLOGIC: Nonfocal. Disoriented times 3. The patient states that he is on a ship, the year is 1950 and the month is October. Cranial nerves II through XII grossly intact. The patient does not cooperate with full neurologic exam. Grips are equal in both upper extremities, negative for pronator drift. Fine motor coordination intact in right and left hand.

TN: Pale pink.

DIAGNOSTIC STUDIES:
CBCD: White blood cell count within normal limits. Hemoglobin and hematocrit mildly decreased at 12.7 and 38.

Basic metabolic panel: BUN mildly increased at 36.3 with a normal glomerular filtration rate greater than 59.

Urinalysis positive for 2+ leukocyte esterase, 20 to 30 white blood cells per high-power field, and a moderate amount of bacteria. Urine culture is pending.

Head CT scan showing nonspecific white matter changes per preliminary radiology report.

ASSESSMENT AND PLAN:
1. Altered mental status, likely secondary to urinary tract infection. We will give antibiotics. There was some question of focal neurologic findings in the emergency room and Montesano Health and Rehab, now resolved. The patient has a history of an upper gastrointestinal bleed. We will consider aspirin. We will discuss this with attending first. We will perform serial neurologic examinations.
2. Urinary tract infection. IV antibiotics were started. This is likely the source of the patient's worsening altered mental status and confusion. We will adjust antimicrobial therapy as needed per urine culture and sensitivities.
3. Acute renal failure. This is mild, with only an elevation of BUN, normal creatinine. We will give IV fluids gently and reassess BUN and creatinine as well as glomerular filtration rate in the a.m.
4. Hypertension, poorly controlled. We will continue the patient's antihypertensives.
5. History of gastrointestinal bleed. We will continue the patient's Carafate, Reglan, and Protonix.
6. Benign prostatic hypertrophy, continue Flomax and finasteride.
7. Deep venous thrombosis prophylaxis with Lovenox.

DISPOSITION:
We will discuss the above plan of care with attending physician, Dr. Bashandy.

Hany G. Bashandy, MD
(Dictated by Daniel Hahn, PA-C)

DA/DAP D: 01/20/2009 at 00:02 T: 01/20/2009 at 04:06 J: 1010366 Doc: 00590835

CAPITAL MEDICAL CENTER
OLYMPIA, WA

OPERATIVE REPORT

DATE OF ADMISSION: 10/21/2008
DATE OF PROCEDURE: 10/21/2008 PT TYPE: P

PREOPERATIVE DIAGNOSIS(ES):
Left leg ischemia.

POSTOPERATIVE DIAGNOSIS(ES):
Left leg ischemia.

ERATION(S) PERFORMED:
t above-knee amputation.

RGEON:
David M Deitz, MD.

ASSISTANT:
Christopher S Johnson, PA.

ANESTHESIA:
Spinal with epidural supplement, Dr. Sharangpani.

INDICATIONS:
The patient is an almost 88-year-old male in whom I did a right-to-left femoral-femoral bypass graft in November 2006 followed 1 week later by a left n-pop below-knee bypass with reverse saphenous vein. This was done for limb lvage. He subsequently developed gangrenous changes in his right leg and I d a right above-knee amputation in January 2007. More recently he developed ulceration on his left heel which has worsened and also has developed multiple ulcerations beginning in the mid left calf. A recent evaluation in the vascular lab revealed that the fem-pop bypass graft was occluded. The femoral-femoral graft was opened. Th left ABI was 0.4. After discussing things with the patient and his family in the office, the decision was made to do a primary above-knee amputation.

FINDINGS:
The muscle tissue appeared to be satisfactorily vascularized. The skin edges at the amputation site looked quite viable.

SCRIPTION:
e patient was brought to the operating room after having been in the holding cea where the spinal anesthetic and epidural catheter were placed. He was entified in the operating room and placed on the table in a supine position. he left lower extremity was prepped and sterilely draped. The left leg below the knee was covered with a stockinette and Coban wrap.

A fishmouth type incision was marked out on the left thigh a short distance above the knee. The skin incisions were made and carried down into the

subcutaneous tissues. The cautery was used to divide the subcutaneous tissue and the muscle tissue. I got down to the femur. It was cleaned circumferentially. I used the periosteal elevator to elevate the periosteum in a proximal direction. The oscillating saw was then used to divide the femur well above the level that the muscle tissue had been divided. Posterior to this, the neurovascular pedicle was identified. The occluded superficial femoral artery was dissected out, clamped, divided, and ligated with 2-0 silk ligatures. The adjacent vein was separately clamped, divided, and ligated with 2-0 silk ligatures and the sciatic nerve was clamped and divided. I then ilized it proximally about 4 cm and clamped it at that level. A 2-0 silk was d to ligate the nerve at that level and it was divided just beyond the more oximal clamp allowing it to retract well up into the stump. The posterior scular tissues and subcutaneous tissues were divided with the cautery and the distal leg was removed from the field. The edge of the femur was smoothed over using the rasp. The stump was irrigated with saline solution. A hemostatic check was made. I then closed the deeper muscular tissue over top of the transected end of the femur with several interrupted 3-0 Vicryl sutures. The superficial fascial layer was then approximated with interrupted 3-0 Vicryl sutures. The subcutaneous tissues were closed with a running 3-0 Vicryl and the skin was then closed with interrupted 3-0 nylon sutures. The wound was cleaned. Gauze 4 x 4, Kerlix wraps, and Ace wraps were applied.

Sponge and needle counts were reported as correct. Blood loss was estimated at cc. The patient was stable on transfer to the recovery room.

David M Deitz, M.D.

CC: Thomas Burghardt, D.P.M.
Craig J Teveliet, MD

DMD:Spheris13895
D: 10/21/08 11:24 T: 10/21/08 12:13 DOCUMENT: 200810212256415800

 ANDREW SR
D000260104

TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS AUDIT

Name of Facility MHR | Address

Family | Admission Number | Room No. | Attending Physician Hing Frank

Date Ordered	Time Ordered	Date Discontinued	Orders
3/28			Vit C DC - Dr. Hing /KBy
	11		

Signature of Nurse Receiving Order KBy | Signature of Physician | Date

	Initials		Initials		Initials	
On MD Order Sheet		Med/Tx Sheet		Date & Time		Communicated
Pharmacy		Nurses Notes		Pt. Care Plan		Signed

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DUPLICATE COPY - Destroy When Original Has Been Received and Placed On Medical Record

NAME - Last, First, Middle Initial | PHYSICIAN | ID#

MD 2011-153821-000005

Form 3245P-RF BRIGGS, Des Moines, Iowa 50306 (800) 247-2343 PRINTED IN U.S.A.

TELEPHONE ORDERS

FACILITY NAME/ADDRESS MHR

PHYSICIAN TELEPHONE ORDERS

RESIDENT NAME [2 - Healthcare Information Readily Identifia...] ROOM # 207 PHYSICIAN Hing

ORDER DATE	ORDER TIME	PHON	CODE	PHYSICIAN ORDERS / NURSING - Circle One	SIG.	INIT.
3-19-11				UA & C&S if indicated		
				Macrobid 100mg po Bid x 10 days		
				pending C&S		
				T.O. Dr. Hing / R Knoll LPN		

NURSE SIGNATURE X. R Knoll LPN DATE 3-19-11 | PHYSICIANS SIGNATURE X DATE

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PHYSICIAN PLEASE SIGN AND RETURN

White/Physician Yellow/DNS Pink/Computer Gold/Pharmacy

ORDER DATE	ORDER TIME	PHON	CODE	PHYSICIAN ORDERS / NURSING - Circle One	SIG.	INIT.
3/16/11	1320			DC Rumeron and		
				per Benadryl.		
				T.O., Dr. Hing		

NURSE SIGNATURE X [signature] (LPN) DATE | PHYSICIANS SIGNATURE X DATE

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PHYSICIAN PLEASE SIGN AND RETURN

White/Physician Yellow/DNS Pink/Computer Gold/Pharmacy

PHYSICIAN'S TELEPHONE ORDERS AUDIT

Name of Facility MHR Address 800 N. Medrano

[2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56....] Admission Number 97-1360 Room No. 207 Attending Physician Dr. Ruben

Date Ordered	Time Ordered	Date Discontinued	Orders
3/16/11		1430	OT Clarification Order - pt. to DC from Skilled OT Services, pt has reached highest obtainable level of function at this time. Richard Ekon OTR/L

Signature of Nurse Receiving Order R Knoll LPN Signature of Physician Date

	Initials		Initials		Initials		
On MD Order Sheet		Med/Tx Sheet		Date & Time		Communicated	
Pharmacy		Nurses Notes		Pt. Care Plan		Signed	

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NAME - Last, First, Middle Initial	PHYSICIAN	ID#
	MD 2011-153821-00005	

Form 3245P-RF BRIGGS, Des Moines, Iowa 50306 (800) 247-2343 PRINTED IN U.S.A.

Date Printed: Feb 23, 2011 05:27:38 PT

Montesano Health and Rehabilitation Center

Facility # WA40590

User: Renee Bureau (Medical Records)

Resident Name: 2 - Healthcare Infor... (9713600) **Location:** 1 207 - 1 **Admission Date:** 2/14/2011

Medical Record #: 9713600 **Gender:** M **Date of Birth:** 2 - Healthcar...

Physician: BUBEN, MICHAEL **Pharmacy:** Payless Pharmacy

Allergies: NKA

Diagnoses: CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6), INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81), CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7), SPASM OF MUSCLE (728.85), UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50), OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99), UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9), LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76), MUSCLE WEAKNESS (GENERALIZED) (728.87), HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00), ESOPHAGEAL REFLUX (530.81)

All Active Orders for March 2011

Pharmacy	Start Date
TREATMENT	
BATH/SHOWER Q WEEK ON SATURDAY (DAY). PROVIDE ASSISTANCE AS NEEDED - - SAT DAY	2/14/2011
MONITOR MASS (L) UPPER HIP AREA Q DAY - - DAY	2/14/2011
MONITOR RED RASH TO TORSO-ARMS POSSIBLE ALLERGIC REACTION TO NEW RX QS - Topical - TIQD	2/14/2011
NYSTATIN POWDER 10,000 UINTS TOPICALLY Q SHIFT PRN RASHY AREAS - - PRN	2/14/2011
PSYCH-BEHAVIORS	
MONITOR FOR S/S OF DEPRESSION Q SHIFT; I.E. CHANGE IN EATING/SLEEP, DECREASED SOCIALIZATION - DESCRIBE ON BACK - - EACH SHIFT +/-	2/14/2011
Bowel/Bladder	
(1) RES. WITH NO BM BY 9TH SHIFT WILL HAVE BOWEL PROGRAM STARTED. DOCUMENT SIZE OF STOOLS QS ON BOWEL MONITORING. SM= SMALL, MED= MEDIUM, LG= LARGE, XL= EXTRA LARGE, D= LOOSE/DIARRHEA. - - DOCBM	2/14/2011
(2) BEGINNING OF 9TH SHIFT RES TO RECEIVE 30cc MOM PO UNLESS DIALYSIS PATIENT - - PRN2	2/14/2011
(3) IF NO RESULTS FROM MOM RES TO RECIEVE ORAL LAXATIVE DULCOLAX 5mg EC TAB PO. - - PRN2	2/14/2011
(4) IF NO RESULTS FROM DULCOLAX TAB, RES TO RECIEVE DULCOLAX SUPPOSITORY 10mg RC - - PRN1	2/14/2011
(5) IF NO RESULTS FROM DULCOLAX SUPPOSITORY, GIVE FLEETS ENEMA 1 RC, IF ORDERED. - - PRN1	2/14/2011
(6) IF NO RESULTS FROM FLEETS ENEMA, CALL MD FOR FURTHER ORDERS - - PRN1	2/14/2011
Standard Medication	
ALBUTEROL NEB Q 2-4 HRS PRN SOB - - PRN SOB	2/14/2011
ALL APPROPRIATE MEDICATIONS MAY BE CRUSHED - Other - INFO	2/14/2011
ASA 325 MG PO QD - - 0800 CAD	2/14/2011
BENADRYL 25 MG PO Q 6 HRS PRN MOD ITCHING - - PRN ITCHING	2/14/2011

Pharmacist		**Signature:**		**Date:**
Recapitulation By Nurse		**Signature:**		**Date:** 2-23-11
Recapitulation By Nurse recap		**Signature:**		**Date:**
Prescribing Physician	BUBEN, MICHAEL	**Signature:**		**Date:**
Orders Noted By		**Signature:**		**Date:**
Pharmacist		**Signature:**		**Date:**

RECEIVED BY
MAR 21 2011

Lamisoptic to coccyx q Sh. ft/prn till excoriation resolved 2/22/11

Resident Name: 2 - Healthcare Infor... (9713600) **Location:** 1 207 - 1 **Admission Date:** 2/14/2011

Standard Medication Continued...

BENADRYL 50 MG PO Q 6 HRS PRN SEVERE ITCHING - - PRN ITCHING	2/14/2011
FeSO4 324 MG PO BID - By mouth (PO) - BID SUPPLEMENT	2/14/2011
FINASTERIDE 5 MG PO QD - (PREGNANT WOMEN SHOULD NOT HANDEL PROSCAR) - By mouth (PO) - 0800 BPH	2/14/2011
FLOMAX 0.4 MG PO QD - By mouth (PO) - QD BPH	2/14/2011
KCL 10 mEq PO QD - - QD HYPOKALEMIA	2/14/2011
OCEAN MIST NASAL SPRAY 1 SPRAY EACH NOSTRIL PRN DRYNESS/IRRITATION - - PRN NASAL DRYNESS/IRRITATION	2/14/2011
REQUIP 1 MG PO QHS - By mouth (PO) - HS RESTLESS LEG	2/14/2011
VITAL SIGNS Q MONTH - - 1XMBP	2/14/2011
ZINC SULFATE 220 MG PO QD - - 0800 SUPPLEMENT	2/14/2011
Treatment-Weekly Skin Assessment	
WEEKLY SKIN ASSESSMENT SATURDAY (DAY). DOCUMENT I/O. (I) = INTACT. (O) = OPEN AREAS/SKIN ISSUES. DOCUMENT (O) FINDINGS ON SKIN CONDITION REPORT. - Other - 1XWSKIN	2/14/2011
Weight	
WEIGH Q MONTH - DOC ON MAR & WEIGHT SHEET - Other - QMONTH	2/14/2011
TREATMENT-EARS	
EAR WASH PER PROTOCOL - - PRN	2/14/2011
MED-ANTIDEPRESSANT	
CITALOPRAM 20 MG PO QAM - By mouth (PO) - QD DEPRESSION	2/14/2011
REMERON 15 MG PO QHS - By mouth (PO) - HS DEPRESSION	2/14/2011
MEDICATION - PAIN	
APAP 650 MG PO/PR Q 4 HRS PRN MILD GENERALIZED PAIN AND/OR PAIN/FEVER TEMPERATURE ABOVE 100 DEGREES, NTE 4GMS ACETAMINOPHEN/24 HRS - PO/PR - PRN PAIN/FEVER	2/14/2011
DO NOT EXCEED 4000 MG ACETAMINOPHEN/24 HRS - Other - INFO	2/14/2011
MONITOR FOR PAIN QS (+)YES / (-) NO - Other - EACH SHIFT +/-	2/14/2011

Pharmacist		Signature:		Date:	
Recapitulation By Nurse		Signature:	[signature]	Date:	2-23-11
Recapitulation By Nurse recap		Signature:		Date:	
Prescribing Physician	BUBEN, MICHAEL	Signature:		Date:	
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Resident Name: 2 - Healthcare Infor... (9713600) **Location:** 1 207 - 1 **Admission Date:** 2/14/2011

MEDICATION-GASTRIC/GUT	
CARAFATE 1gm PO BID - SEPERATE ADMINISTRATION BY 2 HRS FROM OTHER MEDS PER PHARMACY RECS. - By mouth (PO) - BID GASTRITIS	2/14/2011
HOUSE ANTACID 30CCS PO Q 4 HRS PRN GI UPSET. - By mouth (PO) - prn GI UPSET	2/14/2011
OMEPRAZOLE 20 MG PO BID - By mouth (PO) - BID GERD	2/14/2011
MEDICATION-HYPERTENSIVE	
DIOVAN 80 MG PO QD - HOLD IF SBP < 95 - By mouth (PO) - QDBP HTN	2/14/2011
NORVASC 5 MG PO QD - HOLD IF SBP < 95 - By mouth (PO) - QDBP HTN	2/14/2011
MEDICATION-MULTIVITAMINS/HRT	
MVI 1 PO QD - By mouth (PO) - 0800 SUPPLEMENT	2/14/2011
VIT C 500 MG PO BID - By mouth (PO) - BID SUPPLEMENT	2/14/2011
MEDICATION-NOURISHMENTS/HYDRATION	
DIET AS ORDERED BY RD - Other - INFO	2/14/2011
Dietary - Diet	Start Date
Standard Dietary - Diet	
Type: NAS. Texture: Regular Fluid Consistency: Thin Liquid Special Instructions: *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS	2/14/2011
Laboratory	Start Date
LAB-M	
BNP - 1 WEEK - CAD - INFO	2/14/2011
CBC W/DIFF - 1 WEEK - UROSEPSIS - INFO	2/14/2011
CMP 1 WEEK, THEN Q 3 MONTHS - CAD - INFO	2/14/2011
Other	Start Date
PASS	
RESIDENT MAY GO OUT OF FACILITY WITH RESPONSIBLE PARTY AND APPROPRIATE MEDICATIONS.	2/14/2011
VACCINATIONS/PPD	
H1N1 VACCINE GIVEN: 12/28/2009 - INFO	2/14/2011
MAY HAVE ANNUAL FLU VACCINE: 10/19/2009	2/14/2011

Pharmacist		Signature:		Date:	
Recapitulation By Nurse		Signature:		Date:	2-23-11
Recapitulation By Nurse recap		Signature:		Date:	
Prescribing Physician	BUBEN, MICHAEL	Signature:		Date:	
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

VACCINATIONS/PPD Continued..,	
MAY HAVE PNEUMOVAX UPON ADMIT IF NOT PREVIOUSLY GIVEN - IF < 65 YEARS ? REPEAT IN 5 YEARS. LAST GIVEN: 10/26/2009	2/14/2011
PPD ON ADMISSION APISOL 0.1CC INTRADERMALLY. - NIGHT	2/14/2011
PPD PER DSHS PROTOCOL, 2ND STEP PROTOCOL - NOC - NIGHT	2/14/2011
MOBILITY/ACTIVITY STATUS	
MOBILITY STATUS/ACTIVITY LEVEL: AS TOLERATED	2/14/2011
MISC/ GENERAL ORDERS	
ANY PRN MED/TX NOT ADMINISTERED WITHIN 60 DAYS MAY BE DISCONTINUED AFTER ASSESSED AND DOCUMENTED BY A LICENSED NURSE.	2/14/2011
CONTINUE ORDERS FOR 90 DAYS UNLESS OTHERWISE SPECIFIED.	2/14/2011
EVALUATE RESIDENT AND TREAT AS INDICATED FOR: PT, OT & SLP	2/14/2011
FDA APPROVED GENERIC DRUGS EQUIVALENT MAY BE DISPENSED UNLESS OTHERWISE NOTED.	2/14/2011
I CERTIFY RESIDENT REQUIRES NURSING FACILITY CARE.	2/14/2011
I HAVE REVIEWED AND CONCUR WITH THE PRESENT PLAN OF CARE & DISCHARGE PLAN.	2/14/2011

Pharmacist		**Signature:**		**Date:**	
Recapitulation By Nurse		**Signature:**	[signature]	**Date:**	2-23-11
Recapitulation By Nurse recap		**Signature:**		**Date:**	
Prescribing Physician	BUBEN, MICHAEL	**Signature:**		**Date:**	
Orders Noted By		**Signature:**		**Date:**	
Pharmacist		**Signature:**		**Date:**	

Date Printed: Feb 14, 2011 12:41:45 PT

Montesano Health and Rehabilitation Center

Facility # WA40590

User: Renee Bureau (Medical Records)

Resident Name: 2 - Healthcare Inf... (9719600) Location: 1 207 - 1 Admission Date: 2/14/2011

Medical Record #: 9719600 Gender: M Date of Birth: 2 - Healthca...

Physician: BUBEN, MICHAEL Pharmacy: Payless Pharmacy

Allergies: NKA

Diagnoses: CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT (682.6), INF W/MICROORG RESIST-OTH SPEC RX W/RESIST MX RX (V09.81), CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES (682.7), SPASM OF MUSCLE (728.85), UNS GASTRITIS&GASTRODUODITIS W/O MENTION HEMORR (535.50), OTH EXTRAPYRAMIDAL DZ&ABNORM MOVMNT DISORDER (333.99), UNSPECIFIED HEMORRHAGE OF GASTROINTESTINAL TRACT (578.9), LOWER LIMB AMPUTATION, ABOVE KNEE (V49.76), MUSCLE WEAKNESS (GENERALIZED) (728.87), HYPERTROPHY PROSTATE W/O UR OBST & OTH LUTS (600.00), ESOPHAGEAL REFLUX (530.81)

All Active Orders for February 2011

Pharmacy	Start Date
TREATMENT	
BATH/SHOWER Q WEEK ON SATURDAY (DAY), PROVIDE ASSISTANCE AS NEEDED - - SAT:DAY	2/14/2011
MONITOR MASS (L) UPPER HIP AREA Q DAY - - DAY	2/14/2011
MONITOR RED RASH TO TORSO-ARMS POSSIBLE ALLERGIC REACTION TO NEW RX QS - Topical - TIQD	2/14/2011
NYSTATIN POWDER 10,000 UINTS TOPICALLY Q SHIFT PRN RASHY AREAS - - PRN	2/14/2011
PSYCH-BEHAVIORS	
MONITOR FOR S/S OF DEPRESSION Q SHIFT; I.E. CHANGE IN EATING/SLEEP, DECREASED SOCIALIZATION - DESCRIBE ON BACK - - EACH SHIFT +/-	2/14/2011
Bowel/Bladder	
(1) RES. WITH NO BM BY 9TH SHIFT WILL HAVE BOWEL PROGRAM STARTED. DOCUMENT SIZE OF STOOLS QS ON BOWEL MONITORING. BM= SMALL, MED= MEDIUM, LG= LARGE, XL= EXTRA LARGE, D= LOOSE/DIARRHEA, - - DOCBM	2/14/2011
(2) BEGINNING OF 9TH SHIFT RES TO RECEIVE 30cc MOM PO UNLESS DIALYSIS PATIENT - - PRN2	2/14/2011
(3) IF NO RESULTS FROM MOM RES TO RECIEVE ORAL LAXATIVE DULCOLAX 5mg EC TAB PO. - - PRN2	2/14/2011
(4) IF NO RESULTS FROM DULCOLAX TAB, RES TO RECIEVE DULCOLAX SUPPOSITORY 10mg RC - - PRN1	2/14/2011
(5) IF NO RESULTS FROM DULCOLAX SUPPOSITORY, GIVE FLEETS ENEMA 1 RC, IF ORDERED. - - PRN1	2/14/2011
(6) IF NO RESULTS FROM FLEETS ENEMA, CALL MD FOR FURTHER ORDERS - - PRN1	2/14/2011
Standard Medication	
ALBUTEROL NEB Q 2-4 HRS PRN SOB - - PRN SOB	2/14/2011
ALL APPROPRIATE MEDICATIONS MAY BE CRUSHED - Other - INFO	2/14/2011
ASA 325 MG PO QD - - 0800 CAD	2/14/2011

Pharmacist		Signature:		Date:	
Recapitulation By Nurse	R Knoll LPN	Signature:		Date:	2-14-11
Recapitulation By Nurse recap		Signature:		Date:	
Prescribing Physician	BUBEN, MICHAEL	Signature:		Date:	2/15/11
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Date Printed: Feb 14, 201112:41:46 PT

Montesano Health and Rehabilitation Center

Facility # WA40690

User: Renee Bureau (Medical Records)

Resident Name [redacted] 9713800) Location: 1 207 - 1 Admission Date: 2/14/2011

Standard Medication Continued...

DOXYCYCLINE 100 MG PO BID X 7 DAYS - - BIDQ12HR UROSEPSIS End Date: 2/21/2011	2/14/2011
FeSO4 324 MG PO BID - By mouth (PO) - BID SUPPLEMENT	2/14/2011
FINASTERIDE 5 MG PO QD - (PREGNANT WOMEN SHOULD NOT HANDEL PROSCAR) - By mouth (PO) - 0800 BPH	2/14/2011
FLOMAX 0.4 MG PO QD - By mouth (PO) - QD BPH	2/14/2011
KCL 10 mEq PO QD - - QD HYPOKALEMIA	2/14/2011
LEVAQUIN 500 MG PO QD X 7 DAYS - - 0800 UROSEPSIS End Date: 2/21/2011	2/14/2011
OCEAN MIST NASAL SPRAY 1 SPRAY EACH NOSTRIL PRN DRYNESS/IRRITATION - - PRN NASAL DRYNESS/IRRITATION	2/14/2011
REQUIP 1 MG PO QHS - By mouth (PO) - HS RESTLESS LEG	2/14/2011
VITAL SIGNS Q MONTH - - 1XMBP	2/14/2011
ZINC SULFATE 220 MG PO QD - - 0800 SUPPLEMENT	2/14/2011
Treatment-Weekly Skin Assessment	
WEEKLY SKIN ASSESSMENT SATURDAY (DAY). DOCUMENT I/O. (I) = INTACT. (O) = OPEN AREAS/SKIN ISSUES. DOCUMENT (O) FINDINGS ON SKIN CONDITION REPORT. - Other - 1XWSKIN	2/14/2011
Weight	
WEIGH Q MONTH - DOC ON MAR & WEIGHT SHEET - Other - QMONTH	2/14/2011
TREATMENT-EARS	
EAR WASH PER PROTOCOL - - PRN	2/14/2011
MED-ANTIDEPRESSANT	
CITALOPRAM 20 MG PO QAM - By mouth (PO) - QD DEPRESSION	2/14/2011
REMERON 15 MG PO QHS - By mouth (PO) - HS DEPRESSION	2/14/2011
MEDICATION - PAIN	

Pharmacist		Signature:		Date:	
Recapitulation By Nurse		Signature:		Date:	
Recapitulation By Nurse recap		Signature:		Date:	
Prescribing Physician	BUBEN, MICHAEL	Signature:		Date:	
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Date Printed: Feb 14, 2011 12:41:45 PT

Montesano Health and Rehabilitation Center

Facility # WA40880

User: Renee Bureau (Medical Records)

Resident Name: 2 - Healthcare Info... (9713600) Location: 1 207 - 1 Admission Date: 2/14/2011

MEDICATION - PAIN Continued...

APAP 650 MG PO/PR Q 4 HRS PRN MILD GENERALIZED PAIN AND/OR PAIN/FEVER TEMPERATURE ABOVE 100 DEGREES, NTE 4GMS ACETAMINOPHEN/24 HRS - PO/PR - PRN PAIN/FEVER	2/14/2011
DO NOT EXCEED 4000 MG ACETAMINOPHEN/24 HRS - Other - INFO	2/14/2011
MONITOR FOR PAIN QS (+)YES / (-) NO - Other - EACH SHIFT +/-	2/14/2011

MEDICATION-GASTRIC/GUT

CARAFATE 1gm PO BID - SEPERATE ADMINISTRATION BY 2 HRS FROM OTHER MEDS PER PHARMACY RECS. - By mouth (PO) - BID GASTRITIS	2/14/2011
HOUSE ANTACID 30CCS PO Q 4 HRS PRN GI UPSET. - By mouth (PO) - prn GI UPSET	2/14/2011
OMEPRAZOLE 20 MG PO BID - By mouth (PO) - BID GERD	2/14/2011

MEDICATION-HYPERTENSIVE

DIOVAN 80 MG PO QD - HOLD IF SBP < 95 - By mouth (PO) - QDBP HTN	2/14/2011
NORVASC 5 MG PO QD - HOLD IF SBP < 95 - By mouth (PO) - QDBP HTN	2/14/2011

MEDICATION-MULTIVITAMINS/HRT

MVI 1 PO QD - By mouth (PO) - 0800 SUPPLEMENT	2/14/2011
VIT C 500 MG PO BID - By mouth (PO) - BID SUPPLEMENT	2/14/2011

MEDICATION-NOURISHMENTS/HYDRATION

DIET AS ORDERED BY RD - Other - INFO	2/14/2011
Dietary - Diet	Start Date
Standard Dietary - Diet	
Type: NAS. Texture: Regular Fluid Consistency: Thin Liquid Special Instructions: *** LARGER PROTEIN PORTIONS *** MAY HAVE SPECIAL MEALS ON SPECIAL OCCASIONS	2/14/2011
Laboratory	Start Date

LAB-M

BNP - 1 WEEK - CAD - INFO	2/14/2011
CBC W/DIFF - 1 WEEK - UROSEPSIS - INFO	2/14/2011
CMP 1 WEEK, THEN Q 3 MONTHS - CAD - INFO	2/14/2011
Other	Start Date

Pharmacist		Signature:	Date:
Recapitulation By Nurse		Signature:	Date:
Recapitulation By Nurse recap		Signature:	Date:
Prescribing Physician	BUBEN, MICHAEL	Signature:	Date:
Orders Noted By		Signature:	Date:
Pharmacist		Signature:	Date:

Date Printed: Feb 14, 201112:41:45 PT

Montesano Health and Rehabilitation Center

Facility # WA40590

User: Ranea Bureau (Medical Records)

Resident Name: 2 - Healthcare Info... (9713600) Location: 1 207 - 1 Admission Date: 2/14/2011

PASS	
RESIDENT MAY GO OUT OF FACILITY WITH RESPONSIBLE PARTY AND APPROPRIATE MEDICATIONS.	2/14/2011
VACCINATIONS/PPD	
H1N1 VACCINE GIVEN: 12/28/2009 - INFO	2/14/2011
MAY HAVE ANNUAL FLU VACCINE: 10/16/2009	2/14/2011
MAY HAVE PNEUMOVAX UPON ADMIT IF NOT PREVIOUSLY GIVEN - IF < 65 YEARS ? REPEAT IN 5 YEARS. LAST GIVEN: 10/28/2009	2/14/2011
PPD ON ADMISSION APISOL 0.1CC INTRADERMALLY. - NIGHT	2/14/2011
PPD PER DSHS PROTOCOL, 2ND STEP PROTOCOL - NOC - NIGHT	2/14/2011
MOBILITY/ACTIVITY STATUS	
MOBILITY STATUS/ACTIVITY LEVEL: AS TOLERATED	2/14/2011
MISC/ GENERAL ORDERS	
ANY PRN MED/TX NOT ADMINISTERED WITHIN 60 DAYS MAY BE DISCONTINUED AFTER ASSESSED AND DOCUMENTED BY A LICENSED NURSE.	2/14/2011
CONTINUE ORDERS FOR 90 DAYS UNLESS OTHERWISE SPECIFIED.	2/14/2011
EVALUATE RESIDENT AND TREAT AS INDICATED FOR: PT, OT & SLP	2/14/2011
FDA APPROVED GENERIC DRUGS EQUIVALENT MAY BE DISPENSED UNLESS OTHERWISE NOTED.	2/14/2011
I CERTIFY RESIDENT REQUIRES NURSING FACILITY CARE.	2/14/2011
I HAVE REVIEWED AND CONCUR WITH THE PRESENT PLAN OP CARE & DISCHARGE PLAN.	2/14/2011

Benadryl 25-50mg po QID 2-14-11 (itching)

Pharmacist		Signature:		Date:	
Recapitulation By Nurse		Signature:		Date:	
Recapitulation By Nurse recap		Signature:		Date:	
Prescribing Physician	BUBEN, MICHAEL	Signature:	[signature]	Date:	2/15/11
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Date Prt

User: Re
RECORI
Resider

2 - Healthcare Information ...

DR. M. BUBEN
97-1360-3
RM# 207.1

Pt. ....

Montesano Health and Rehabilitation Center

Facility # WA40590

Location: -
Gender:
Pharmacy: PAYLESS

Admission Date: 2/14/11
Date of Birth: ~~01/01/2001~~

Allergies: To Be Determined

Diagnoses: HX- gerd, AFib, Depression, CAD 2/14/11

All Active Orders for February 2011

Pharmacy	Start Date
Admission Orders	
ADMIT TO MONTESANO HEALTH & REHABILITATION CENTER FOR SKILLED/CERTIFIED NURSING CARE BY DR. Buben.	3/3/2009
ADMITTING DIAGNOSIS #1 Inflammatory Systemic Response syndrome; #2 UROSepsis; #3 Skin Candidias Peri/scrotum; #4 ENCephalopathy.	3/3/2009
EVALUATE RESIDENT AND TREAT AS INDICATED FOR: PT OT SLP HEARING ___ OTHER (SPECIFY) ___.	3/3/2009
MOBILITY STATUS/ ACTIVITY LEVEL: AS tol	3/3/2009
RESIDENT IS AWARE OF DIAGNOSES: YES: NO: ___. IF NO, REASON: _____	3/3/2009
RESIDENT MAY GO OUT OF FACILITY WITH RESPONSIBLE PARTY AND APPROPRIATE MEDICATIONS.	3/3/2009
Medication-pain management	
APAP 650 MG PO/PR Q 4 HRS PRN MILD GENERALIZED PAIN AND/OR TEMPERATURE ABOVE 100 DEGREES, NTE 4 GMS ACETAMINOPHEN/ 24 HRS. - PRN PAIN/ FEVER	3/3/2009
Standard Medication	
ALL APPROPRIATE MEDICATION MAY BE CRUSHED	3/3/2009
VITAL SIGNS Q MONTH	3/3/2009
Medication-gastric/gut	
HOUSE ANTACID 30 CC'S PO Q 4 HRS PRN GI UPSET. - PRN GI UPSET	3/3/2009
Dietary	**Start Date**
Standard Dietary	
Special Instructions: DIET TEXTURE: (CIRCLE ONE) REGULAR; MECHANICAL SOFT; PUREE.	3/3/2009
Special Instructions: DIET TYPE: (CIRCLE ONE) GENERAL; NAS; NCS; NAS/NCS.	3/3/2009
Special Instructions: LIQUID CONSISTENCY: (CIRCLE ONE) THIN; HONEY THICK, NECTAR THICK; SPOON THICK.	3/3/2009
Other	**Start Date**
Vaccinations/ PPD	
MAY HAVE ANNUAL FLU VACCINE.	3/3/2009

Recapitulation By Nurse	_____	**Signature:**	_____	**Date:**	2/14/11
Prescribing Physician	_____	**Signature:**	_____	**Date:**	_____
Orders Noted By	_____	**Signature:**	_____	**Date:**	_____
Pharmacist	_____	**Signature:**	_____	**Date:**	_____

Admit under services of DR Buben
Please use house protocols and Note Clarifications

MD 2011-153821-000095

Vaccinations/ PPD Continued...

MAY HAVE PNEUMOVAX UPON ADMIT IF NOT PREVIOUSLY GIVEN - IF < 65 YEARS - REPEAT IN 5 YEARS. LAST GIVEN:	3/3/2009

Misc/General Orders

ANY PRN MED/TX NOT ADMINISTRATED WITHIN 60 DAYS MAY BE DISCONTINUED AFTER ASSESSED AND DOCUMENTED BY A LICENSED NURSE.	3/3/2009
CONTINUE ORDERS FOR 90 DAYS UNLESS OTHERWISE SPECIFIED.	3/3/2009
FDA APPROVED GENERIC DRUG EQUIVALENT MAY BE DISPENSED UNLESS OTHERWISE NOTED.	3/3/2009
I CERTIFY RESIDENT REQUIRES NURSING FACILITY CARE.	3/3/2009
I HAVE REVIEWED AND CONCUR WITH THE PRESENT PLAN OF CARE & DISCHARGE PLAN.	3/3/2009

All Active Orders for February 2011

Pharmacy	Start Date
Admission Orders	
VITALS SIGNS PER FACILITY PROTOCOL. - Other - 1XMBP	10/1/2009
Medication-pain management	
MONITOR FOR PAIN QS (+) YES (-) NO - Other - TIDO#	3/3/2009
VISUAL CHECK FOR PAIN PATCH QS (SITE-ie RB- ® BACK, LB=(L) BACK etc) - Other - EACH-PPC	10/1/2009
Standard Medication	
ON ADMISSION WEIGH Q DAY X 3 DAYS THEN WEIGH WEEKLY ONGOING. - Other - DAY	12/18/2009
PPD ON ADMISSION APISOL 0.1CC INTRADERMALLY. - Other - NIGHT	3/3/2009
PPD PER DSHS PROTOCOL, 2ND STEP PROTOCOL - NOC - Other - NIGHT	3/3/2009
Bowel Medication	
(1) RES WITH NO BM BY 9TH SHIFT WILL HAVE BOWEL PROGRAM STARTED. DOCUMENT SIZE OF STOOLS QS. DOCUMENT SIZE: ON BOWEL MONITORING. SM= SMALL. MED= MEDIUM, LG= LARGE, XL= EXTRA LARGE, D= LOOSE/DIARRHEA - Other - DOCBM	6/28/2010
(2) BEGINNING OF 9TH SHIFT RES TO RECIEVE 30cc MOM PO UNLESS DIALYSIS PT - PO - PRN	6/28/2010
(3) IF NO RESULTS FROM MOM RES TO RECIEVE ORAL LAXATIVE DULCOLAX 5 MG EC TAB PO - PO - PRN	6/28/2010
(4) IF NO RESULTS FROM DULCOLAX TAB, RES TO RECIEVE DULCOLAX SUPPOSITORY 10 MG RC. - PR - PRN	6/28/2010
(5) IF NO RESULTS FROM DULCOLAX SUPPOSITORY, GIVE FLEET ENEMA 1 RC, IF ORDERED. - Other - PRN	6/28/2010
(6) IF NO RESULTS FROM FLEETS ENEMA, CALL MD FOR FURTHER ORDERS. - PR - PRN	6/28/2010
Standard Treatment	
BATH/SHOWER Q WEEK ON SAT DAY. PROVIDE ASSISTANCE AS NEEDED - Other - QWK	12/18/2009
Treatment-weekly skin assessment	
WEEKLY SKIN ASSESSMENT. DOCUMENT I/O. (I) = INTACT. (O) = OPEN AREA/SKIN ISSUES. DOCUMENT (O) FINDINGS ON SKIN CONDITION REPORT. - Other - 1XWSKIN	12/18/2009
Treatment-ears	
EAR WASH PER PROTOCOL. - Other - INFO	12/18/2009

Recapitulation By Nurse		Signature:		Date:	2/14/11
Prescribing Physician		Signature:		Date:	
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Date Print
User: Ren
RECORDS
Residen

2 - Healthcare Information ...

DR. M. BUBEN
97-1360-3
RM# 207.1

Montesano Health and Rehabilitation Center

Facility # WA40590

Location: -

Admission Date:

Laboratory	Start Date
Standard Lab	
CBC W/DIF, BNP & CMP ON ADMIT FOR BASELINE - INFO	11/1/2009

Recapitulation By Nurse		Signature:	K Bell	Date:	2/14/11
Prescribing Physician	BUBEN, MICHAEL	Signature:		Date:	
Orders Noted By		Signature:		Date:	
Pharmacist		Signature:		Date:	

Monitor Red Rash to torso-Arms Possible Allergic Reaction to New Rx QS,
Vit C 500 mg Po BID - Supplement.
Zinc Sulfate 220 mg PO QD - Supplement.
~~Cont LABS As Prior Admit Lytes Q6mo, Dc/error~~
NORVASC 5mg PO QD HTN
DIOVan 80mg Po QD HTN
Finasteride 5mg Po QD BPH
MVI Po QD - supplement
FeSO4 324 mg PO BID - Supplmt -
KCL 10meq PO QD - Replacement Diuretic use
Flomax 0.4 mg Po QD - BPH
Omeprazole 20mg PO BID - gerd
CARAfate 1gm Po BID - gerd
Requip 1mg PO QHS - Involuntary movements
Ocean mist 1 spray each NOSTRIL PRN/dryness
Citalopram 20mg Po QAm - depression
Remeron 15mg Po QHS - Depression
Doxycycline 100mg PO BID X 7 Days - urosepsis
Levaquin 500 Po QD X 7 Days - urosepsis
Albuterol Neb q 2-4 HR PRN - SOB
ASA 325 mg PO QD - CAD

CBC & Diff - one week - urosepsis
BNP - one week - CAD
CMP - one week - CAD then Q3 months

Noted K Bell 2/14/11

K Bell

DNRes given [illegible]
I gave NARCAN then draw Old Hosp
False positive Result 20 to NARCAN

230

NURSING HOME ADMIT ORDERS

GHHR ____ PCC ____ MH & Rehab X Other ____

DIAGNOSIS SUMMARY

CODES

X DX: ADMITTING DIAGNOSIS Encephalopathy 2/2 Oxycodone intoxication (intentional vs accid) DX ( )
X DX: ADMITTING DIAGNOSIS ~~[illegible]~~ 2/2 UTI, SIRS DX ( )
X DX: ADMITTING DIAGNOSIS Depression DX ( )
X DX: ADMITTING DIAGNOSIS Candidasis Skin DX ( )
X DX: ADMITTING DIAGNOSIS A.fib HTN, GERD DX ( )

O RESIDENT IS AWARE OF DIAGNOSIS: ✓ YES ____ NO
IF NO, REASON: ____

C CODE STATUS: DNR/DNI PROGNOSIS: Fair

DIETARY ORDERS

D DIET: ADA 1800kcal TEXTURE: Regular

DIETARY SUPPLEMENTS

DS NOURISHMENTS / SUPPLEMENTS PER R.D. ✓ YES ____ NO

D MAY HAVE REGULAR DIET ON HOLIDAYS AND / OR SPECIAL OCCASIONS ✓ YES ____ NO

D MAY HAVE ALCOHOLIC BEVERAGES NOT TO EXCEED (3) BEVERAGES PER WEEK
✓ YES ____ NO

MEDICATION MESSAGE

MM FLU VACCINE ANNUALLY: ✓ YES ____ NO

MM PNEUMOVAC X's 1 (UNLESS PATIENT HAS ALREADY HAD): ✓ YES ____ NO

MM PPD PER DSHSH REGULATIONS

MM MAY USE GENERIC EQUIVALENT FOR ORDERED DRUGS: ✓ YES ____ NO

MM DISCONTINUE ALL PRN MEDS IF NOT USED FOR MORE THAN 60 DAYS PER PHARMACY:
✓ YES ____ NO

MM MAY CRUSH MEDICATIONS AND GIVE WITH PUREED FOODS: ✓ YES ____ NO

MM NATURAL FRUIT AND BRAN LAXATIVE 1 – 2 TSP PO EVERY DAY PRN CONSTIPATION:
✓ YES ____ NO

G013321377
2 - Healthcare Infor...
DOB 2 - Health... M AGE: 90
02/09/11 ER

MD 2011 15 M0102440 000098

Feb. 14. 2011 11:18AM No. 0361 P. 1

MEDICATION ORDERS

M SODIUM PHOSPHATE / SOD BIPHOS (FLEET ENEMA) PER RECTUM Q 3RD DAY PRN CONSTIPATION IF SUPPOSITORY NOT EFFECTIVE: ✓ YES ____ NO

M BISACODYL SUPPOSITORY 10 MG (DUCOLAX SUPPOSITORY) 10 MG I P.R. Q 3RD DAY PRN / CONSTIPATION IF GLYCERIN SUPPOSITORY NOT EFFECTIVE: ✓ YES ____ NO

M ACETAMINOPHEN 650 MG (TYLENOL) 650 MG RS Q 3 – 4 HOURS PRN (TOTAL NTE 4000 MG) PAIN OR ELEVATED TEMP: ✓ YES ____ NO

M HOUSE ANTACID 30 ML PO Q 4 HRS PRN G.I. UPSET: ____ YES ____ NO

M MILK OF MAGNESIA 30 ML PO HS PRN NO BM FOR 3 DAYS: ____ YES ____ NO

SKIN ORDERS

SO PATIENT HAS CURRENT SKIN ISSUES / DECUBES/ CELLULITIS: ____ YES ✓ NO
(IF YES), WHAT KIND AND TREATMENT: _____

_____

SO VITAMIN C 500 MG TABLET (ASCORBIC ACID) PO BID SUPPLEMENT R / T SKIN ISSUES: ✓ YES ____ NO

SO ZINC SULFATE 220 MG CAP QD SUPPLEMENT R / T SKIN ISSUES: ____ YES ____ NO

ORTHOPEDIC ORDERS / WOUND CARE / WOUND VAC, ETC.

_____

_____

_____

_____

ACTIVITY ORDERS

AO MAY LEAVE FACILITY FOR OUTINGS WITH FAMILY MEMBERS, ACTIVITY DEPARTMENT, OR OTHER: ✓ YES ____ NO WITH MEDICATIONS: ✓ YES ____ NO

AO RESPONSIBLE PERSON: ✓ YES ____ NO

MOBILITY STATUS

MS ACTIVITY LEVEL: POOR

MS MOBILITY STATUS: POOR

MS REHAB POTENTIAL: POOR

G013321377

2 - Healthcare Infor...
2 - Health...

DOB 02/09/11 ER AGE: 90

M0102440

PHYSICAL THERAPY ORDERS

PT PHYSICAL THERAPY EVAL AND TREAT AS APPROPRIATE: ✓ YES ____ NO

-- CLARIFICATION ORDERS TO FOLLOW

OCCUPATIONAL THERAPY ORDERS

OT OCCUPATIONAL THERAPY EVAL & TREAT AS APPROPRIATE: ✓ YES ____ NO

-- CLARIFICATION ORDERS TO FOLLOW

ACTIVITIES

MAY PARTICIPATE IN ACTIVITIES AS APPROPRIATE: ✓ YES ____ NO

____ LIGHT ✓ MODERATE ____ EXTENSIVE

SPEECH THERAPY ORDERS

ST SPEECH THERAPY EVAL & TREAT AS APPROPRAITE: ✓ YES ____ NO

-- CLARIFICATION ORDERS AS FOLLOWS

ANCILLARY / OTHER ORDERS

O	MAY HAVE: PODIATRY CONSULT PRN:	✓ YES	____ NO
	OPTOMETRY CONSULT PRN:	✓ YES	____ NO
	AUDIOLOGY CONSULT PRN:	✓ YES	____ NO
	DENTAL CONSULT PRN:	✓ YES	____ NO
	MENTAL HEALTH CONSULT PRN:	✓ YES	____ NO

LABORATORY / X-RAY ORDERS

L LYTES Q 6 MONTHS IF RESIDENT ON A CARDIOTONIC MEDICATION OR DIURETIC:
✓ YES ____ NO

L CBC: _____

L DIG: _____

L UA: _____

L OTHER: _____

OTHER TREATMENTS

OT _____

OT _____

OT _____

G013321377

2 - Healthcare Infor... 2 - Healthc...

DOB M AGE: 90
02/09/11 ER

M0102440

MEDICATIONS

M	NORVASC 5mg PO daily		
M	DIOVAN 80mg PO daily		
M	FINASTERIDE 5mg PO daily		
M	MVI PO daily		
M	Fe SULFATE 325mg PO BID		
M	KCl 10meq PO daily		
7/10MOA M	PRAVA 0.4mg PO daily		
M	OMEPRAZOLE 20mg PO BID		
M	CARAFATE 1g PO BID		
M	REQUIP 1mg PO qhs		
M	OCEAN MIST 1 spray each nostril PRN dryness		
M	CITALOPRAM 20mg PO qam		
M	RONERON 15mg PO qhs		
M	DOXYCYCLINE 100mg PO BID x 7 days		
M	LEVAQUIN 500mg PO daily x 7 days		
M	ALBUTEROL neb q 2-4h PRN SOA		
M	ASA 325mg PO daily		
M			

CERTIFICATION / RECERTIFICATION

C CONTINUE ABOVE ORDERS X's 90 DAYS UNLESS OTHERWISE SPECIFIED.

C I CERTIFY THAT THIS RESIDENT REQUIRES CONTINUED SKILLED LEVEL OF CARE ON AN INPATIENT BASIS.

C ADMIT TO THE NURSING HOME UNDER THE CARE OF DR. BABEN

PHYSICIAN SIGNATURE — DATE / TIME: 2/14/11 1000

G013321377

DOB [illegible] AGE: 90
02/09/11 ER
M0102440

IDENTIFICATION
This 90-year-old male presents from Montesano Health and Rehabilitation Center because of the sudden onset of change in mental status. He responded some to Narcan initially and now has decreasing mental status. He was intubated in the emergency department.

HISTORY OF PRESENT ILLNESS
He was in his usual state of fair health, living at Montesano Health and Rehabilitation Center with his wife. His son reports that he saw the patient at lunch and he was in his usual state of health. Then, reportedly, he was found to be obtunded with shallow respirations. He had only moaning. He did wake up for the paramedics briefly after Narcan. At that time, he was transferred to the emergency department.

There, his paperwork showed he was DNR and they contacted the family. The patient was started on a Narcan drip. Because of intubation, he was given empiric ceftriaxone, 1 gram IV, normal saline boluses, and Zosyn 3.375 mg.

It was decided that the patient required intubation due to increasing difficulty protecting his airway. He had hypotension, responding to IV fluids. Upon talking with the family, he told his family that he wanted intubation if it was thought to be reversible, and the decision was made to pursue intubation.

After intubation, part of the workup included a toxicology screen, which was positive for oxycodone. The nursing home was contacted again and there was reportedly no prescribed oxycodone and no obvious thought how the patient could receive oxycodone.

His blood sugar at the time was 253. His family said this was a sudden change in his mental status. He has required intubation at times in the past and has had episodes of urinary tract infections, thought to be secondary to methicillin-resistant Staphylococcus aureus. He has had significant peripheral vascular disease and has been on chronic medications. He has had no fevers, chills, or other complaints.

ALLERGIES
1. BACTRIM.
2. CLINDAMYCIN.

PAST MEDICAL HISTORY
1. Peripheral vascular disease, status post amputation bilaterally above the knee.
2. Hypertension.
3. GERD.
4. Peptic ulcer disease.
5. Hyperlipidemia.
6. BPH.

7. Iron-deficiency anemia.
8. History of GI bleed in 2008.
9. Depression.
10. Chronic atrial fibrillation.

MEDICATIONS
1. Remeron 15 mg p.o. q.h.s.
2. Citalopram 20 mg p.o. daily.
3. Norvasc 5 mg daily.
4. Diovan 80 mg daily.
5. Finasteride 8 mg p.o. daily.
6. Vitamin C 500 mg daily.
7. Multivitamin 1 daily.
8. Iron sulfate 325 mg daily.
9. Flomax 0.4 mg p.o. daily.
10. Omeprazole 20 mg p.o. daily.
11. Carafate 1 gram p.o. b.i.d.
12. Requip 1 mg p.o. q.h.s.

SOCIAL HISTORY
He lives at Montesano Health and Rehabilitation Center. He has a wife. A son and daughter-in-law assist in his care. Nonsmoker. No history of alcohol intake. No recreational drug use.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 136/66, heart rate 64, respiratory rate 18, temperature 97.6, oxygen saturation 100% on the ventilator, 100% FiO2, tidal volume 500, PRVC 18, PEEP 5, pH 7.29, PCO2 28, PO2 207. Weight 54.5 kg.

NECK: No evidence of JVD.

LUNGS: Clear. Decreased in the bases.

HEART: Regular rate and rhythm.

ABDOMEN: Soft, nontender. No hepatosplenomegaly or masses.

EXTREMITIES: No clubbing, cyanosis or edema. As listed above, bilateral above-the-knee amputations.

NEUROLOGIC: Follows some commands. Moves extremities.

DIAGNOSTIC STUDIES
Pertinent lab work includes a sodium of 141, potassium 5.2, chloride 111, bicarbonate 23, BUN 40, creatinine 1.2, and glucose 291. White blood cell count 16.1, increased polys but no bandemia, hematocrit 41, MCV 95.9, platelets 230,000. Magnesium 2.2, bilirubin 0.1, ALT 15, AST 21, alkaline phosphatase 105. Troponin T less than 0.01.

Blood cultures x2 obtained. Sputum x2 obtained.

Urinalysis: 2+ leukocyte esterase, 1-5 white blood cells; culture pending.

Toxicology screen positive for oxycodone. A repeat was requested and that too was positive for oxycodone.

A head CT without contrast shows small-vessel disease.

Chest x-ray: No focal airspace disease. ET tube placement okay.

EKG: Atrial fibrillation at a rate of 102. Slow R wave progression. Nonspecific ST-T wave changes.

ASSESSMENT AND PLAN

1. Acute respiratory failure, obtunded, encephalopathic, unable to protect airway. This could possibly be secondary to oxycodone toxicity. This, however, was not prescribed and it is unclear exactly how the patient could have received this. A repeat toxicology screen, however, was positive. It certainly could be a real ingestion. It could be a false positive. His condition could also be sepsis secondary to urinary tract infection or possibly pneumonia. Sepsis can occasionally improve with Narcan as well temporarily and his episode was also complicated by hypotension. This could be systemic inflammatory response syndrome or sepsis. No obvious infiltrate. Clinically improved at this time. Long family discussion. We will attempt weaning parameters, hoping to extubate him and will follow sputum cultures carefully.

2. Pyuria. This could also be a urinary tract infection. The patient is on ceftriaxone. Follow cultures. IV hydration.

3. Systemic inflammatory response syndrome, present on admission, now with mild acute renal failure and dehydration. Aggressively hydrate.

4. Depression. Continue medications.

5. Candida of the skin, also suggested by sputum Gram's stain. Fluconazole and nystatin powder to skin folds. Multivitamin, zinc, vitamin C.

6. Gastroesophageal reflux. Continue Protonix.

7. Deep venous thrombosis prophylaxis. Lovenox subcutaneously 30 mg daily.

8. Hyperglycemia. Could be secondary to acute illness response. Check hemoglobin A1c. Sliding-scale insulin.

9. EKG showed atrial fibrillation, which is chronic. Rate controlled. Continue aspirin for cerebrovascular accident prophylaxis. Consider checking an echocardiogram.

10. Antihypertensives. Hold tonight in a setting of hypotension.

_____

Barbara L. Givens, MD Date/Time

GIVBA/MEM D: 02/13/2011 at 19:02 T: 02/13/2011 at 19:19 J: 10644505 Doc: 20048393

CC: Michael Buben, DO

STAY NUMBER	ADMIT DATE	ADMIT TIME	ROOM/BED	PREVIOUS NUMBER & DATE	MRN
G013321377	02/09/11	0020	ED/05		M0102440

PATIENT NAME	DATE OF BIRTH	AGE	SEX	MS		RACE	RELIGION	PT	F/C	HOS. SERV
2 - Healthcare Information Rea...	2 - Healthcare ...	90	M	M	ER	W	NO	REG	MC	ER

PATIENT ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	OCC CODE
2 - Healthcare Information Readily Identifiable to a Perso...	2 - Healthcare Infor...	2 -...	2 - Healthc...	2 - Healthcare Information R...	02/09/11
PATIENT ALTERNATE ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	

PATIENT S.S.NO(M.C.NC.)	OCCUPATION	EMPLOYER	SM/NON	ER. ADMIT	DR. NUMBER	ATTENDING DR.
2 - Healthcare Informati...	NONE	RETIRED	N			

AILMENT (DIAG) / REASON FOR VISIT	ACCOMP BY	MODE OF TRANS	ADMIT CLRK	DISCHARGE DATE	DISH.TIME	TRANSFERRED TO
AMB PT/AMS;		AM	MWI			

RESPONSIBLE PARTY INFORMATION

GUARANTOR NAME	RELATIONSHIP	TELEPHONE NUMBER	GUARANTOR EMPLOYER
2 - Healthcare Information Readily ...	SA	2 - Healthcare Information R...	RETIRED

GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUARANTOR S.S. NO.
2 - Healthcare Information Rea...	2 - Healthcare ...	2 - ...	2 - Healt...	2 - Healthcare Informati...

INSURANCE INFORMATION

PLAN PRIORITY		POLICY NAME	POLICY I.D. (S.S.)	GROUP NUMBER	POLICY HOLDER	RELATIONSHIP
01		MEDICARE	2 - Healthcare In... 8A		2 - Healthcare Information Readily Identifi...	SA
02		ILWU PMA COAST	2 - Healthcare Inf...	65025/LOCAL		SA
03		MEDICAID MC SU	101774164WA			SA

PERSON TO CONTACT IN EMERGENCY

NEAREST RELATIVE AND ALTERNATE	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP
FOULDS, RONALD JR	HOQUIAM, WA 98550	(360)533-5767	SO
COPELAND, JIM	MONTESANO, WA 98563	(360)249-5951	SO

ER PHYSICIAN: BUCJU			
ADMITTING PHYSICIAN:			
FAMILY PHYSICIAN / PRIMARY CARE: BUBEN, MICHAEL C		ADVANCE DIRECTIVES: NO COPY PROVIDED	
OTHER PROVIDERS:			
ADMITTING DIAGNOSIS:		Restricted Directory =	
PRINCIPAL DIAGNOSIS (NO ABBREVIATIONS):		Patient Primary Language: ENGLISH	
ADDITIONAL DIAGNOSIS:		4 step smoking brochure given ? D	
OPERATIONS:		Patient informed and understands methods available to report safety concerns? Y	
COMPLICATIONS:			

Grays Harbor COMMUNITY HOSPITAL

DEMOGRAPHIC FACE SHEET

G013321377

2 - Healthcare Information Rea...

DOB 2 - Healthcare I... M AGE: 90

02/09/11 ER

M0102440

M.DEMOFS
FORM #368400

REVISED 07/02/09

02/10/11

PEDIATRIC SAFETY / SECURITY
PINK WRISTBAND: ☐ PATIENT ☐ RESPONSIBLE ADULT
☐ RESPONSIBLE ADULT W/PATIENT AT ALL TIMES

PMD: Buben

ALLERGIES: NKDA
Bactrim, Clinda

ESI 1 2 (3) 4 5 | MODE: ☑ EMS ☐ WALK ☐ W/C ☐ CARRIED ☐ SCCC ☐ POLICE

TRIAGE: TIME: 0025 CHIEF COMPLAINT: from MHR - unresponsive, pupils pinpoint - given 0.4mg Narcan - became responsive initially diaphoretic, SpO2: 79% - p med SpO2 ↑ 98% 15 L NRB BS: 253 - NO CODE

INTERVENTIONS: ☐ NONE ☐ ICE ☐ ELEVATE ☐ PRESSURE DRESSING ☐ C COLLAR ☐ BLOOD DRAW ☐ CBG RN.

TIME	TEMP	PULSE	RESP	BP	SPO2	O2	PAIN SCORE
0025	(TA) R 96.2 O	101	14	127/75	92%	RA	0 /10

TETANUS UTD (< 5 YRS) ☐ Y ☐ N
IMMUNIZATIONS (PEDS) ☐ Y ☐ N
LMP:
☐ HYST
☐ BTL

RE✓ TIME ____ Pain ____ /10 BP ____ T ____ P ____ R ____ SpO2 ____ ____ RN./EDT
TIME ____ Pain ____ /10 BP ____ T ____ P ____ R ____ SpO2 ____ ____ RN./EDT

ORDER TIME: 1.) 0034 2.) 0056 3.) ____ 4.) ____ 5.) ____

LAB

☐ CBCD ☐ CMPR ☐ BNPEP (2) ☑ Ammonia
☐ Hemoglobin ☐ BMPR ☐ CK ☐ Lactic Acid
☐ Hematocrit ☐ Uric Acid ☐ CKMB ☐ CRP
☐ ESR ☐ Amylase ☐ TropT ☐ T&C ____ units
☐ PT/INR ☐ Lipase (1) ☒ ETOH ☐ GT Screen
☐ PTT ☐ GGT ☐ Salicylate ☐ GT Hold
☐ D-DIMER ☐ Ketones ☐ Acetaminophen Other ____
☐ Influenza ☐ Dig Level ☐ RH
☐ Mono Spot ☐ Dilantin ☐ T_4
☐ VBG ☐ HCG (Pregs) ☐ TSH
☐ ABG ☐ HCG (Quant) (1) ☒ UAM ____ cath
☐ RA ☐ Preg (Urine) (1) ☒ DOAS Urine
☐ O_2 ____ ☐ Myoglobin ☐ ECG

MICRO

☐ GCSC ☐ CHLFA ☐ WTMT
☐ Stool GS ☐ STL Culture
☐ Stool OP ☐ Cdiff Tox
☐ RSV
☐ BSSC (Rapid Strep)
☐ UA C/S
(2) ☑ B Culture
☐ 1 Set ☑ 2 Sets
☐ Ped (BCP)
☐ Wound Cult.
Site ____
Source ____
☐ Sputum

PANELS

(1) ☒ Cardiac
☐ Trauma
☐ Lumbar Puncture

X-RAYS ☐ DO NOT STAND PATIENT

☐ CXR ☐ Port. ☐ PA/LAT
☐ C Spine (Spiccomp)
☐ Lateral C Spine ☐ Port
☐ T Spine (Spits)
☐ L/S Spine (Spits)
☐ AAS
☐ KUB

R L Ankle/Foot
R L Tib/Fib
R L Knee
R L Femur
R L Hip/Pelvis
R L Hand
R L Wrist / FA / Elbow

R L Humerus
R L Shoulder
R L Clavicle
PT HX ____

EC

☐ Echo
☐ Carotid Doppler
☐ DVT
R ____ L ____ B ____

N. MED

☐ Resting Cardiolyte
HX ____

☐ Prior ECG ☐ HP ☐ ED
☐ Old Records
Hosp. ____
When ____

NIWR 1) ____
2) ____
3) ____

D/C WHERE CCU-5
HOW: Stretcher
TIME 0450

PHYSICIAN / MID-LEVEL SIGNATURE

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT ADMISSION RECORD

ER723-501 (10/09)

PATIENT CHART

G013321377
DOB 02/09/11 ER AGE: 90
M0102440

02/10/11

M.EDADMREC

CC - feels "rummy"

45 **Altered Mental Status**

Sepsis / HHNC / Seizure / ICH / CO / CVA

DATE: 2/9 TIME: 0040 Dr.: Buell EMS Arrival

HISTORIAN: patient family EMS NH records

AGE 90 (M) F

UNABLE TO OBTAIN HISTORY DUE TO: pt's mental status MS

HPI

chief complaint: decreased mental status / confusion
low blood sugar / diabetic fever

onset / duration: tonight
per son; normal at dinner
upon waking cannot confirm onset
gone now better continues in ED more than 3 hours
gradual-onset / sudden-onset / intermittent / constant

character of altered mental status:
disoriented / confused / combative / agitated / trouble concentrating
unresponsive / seizure activity / decreased responsiveness

context:
found unresponsive / unknown duration
by nursing home staff bystander family:
dextrostick PTA (250) given D50 / Narcan PTA
good / marginal / no response
recent / heavy alcohol intake (beer / wine / liquor)
last drink:
drug abuse / overdose
trauma head injury
infection / other ill contacts unknown

baseline
Cognitive: alert, oriented x3 / alert but disoriented / alert but confused / poor alertness / memory loss
Gait: walks w/o assistance / uses a cane / walker / walks only w/ assistance / stands for transfers / unable to walk

associated symptoms:
fever / chills / sweaty
chest pain
neck / back pain
hurts to breathe / short of breath
headache
new weakness RUE RLE LUE LLE R/L facial general (diffuse)
altered sensation RUE RLE LUE LLE R/L facial
falling injury
decreased ability to stand / walk weak difficult off balance cannot walk cannot stand
fainting / dizzy
involuntary seizure / movements

Similar symptoms previously

Recently seen / treated by doctor

ROS - when awake, felt well at bed time

CONST NO HA/N/V
recent illness
EYES / ENT
vision change / problems
sore throat / dental problems
trouble swallowing
CVS / PULMONARY
palpitations
cough bloody / productive
GI / GU
nausea / vomiting
abdominal pain
diarrhea / black / bloody stool
problems urinating limited by ↓ LOC
FEMALE GENITAL
LNMP preg post-menop
MS / SKIN / LYMPH
joint pain
leg / ankle swelling
rash
swollen glands
NEURO (see HPI) / PSYCH
depression / anxiety
☐ all systems neg except as marked

PAST HX GERD / PUD / gastritis

RELATED PAST HX
confusion / dementia
CVA / TIA bleed deficit
diabetes Type 1 Type 2
diet / oral / insulin neuropathy
hepatitis / cirrhosis
overdose
seizure disorder
cardiac disease
angina MI CHF
GI bleeding
hyperlipidemia
hypertension
immunosuppressed AIDS
insect bite
lung disease asthma COPD
old records reviewed / summary:
BPH PUD anemia
h/o GIB

Surgeries / Procedures none (B) AKA
any recent surgery
appendectomy
CABG
cholecystectomy
hysterectomy / BTL / C-section
pacemaker
tonsillectomy

Imaging previous CT / MRI / US date
☐ Immunization UTD

Medications none see nurses note
ASA clopidogrel warfarin LMWH
NSAID acetaminophen narcotic chronic
new medications

Allergies NKDA
see nurses note
antibiotic

SOCIAL HX smoker drugs
alcohol (recent / heavy / occasional) occupation
living situation alone family friend group (care facility) c wife

FAMILY HX stroke migraines CAD HTN

☐ Nursing Assessment Reviewed ☑ Initial Vital Signs Reviewed ☐ Telemetry
BP 107/75 HR 101 RR 14 Temp 96
Pulse Ox 92 % (RA) O2 interp nml hypoxic

PHYSICAL EXAM
EXAM LIMITED BY:
General Appearance mild / moderate / severe distress
appears well
alert
airway intact
lethargic / obtunded / combative
apneic

Grays Harbor Community Hospital

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

ER 724-045 Rev. 07 / 09 Pg 1 of 2

G013321377
2 - Healthcare Informa...
DOB 2 - Healt... M AGE: 90
02/09/11 ER
M0102440

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02/10/11

02/10/11

Pt re-eval- hypotensive, ↓RR, O2 87% on ∞ - little response to sternal rub, pinpoint pupils - Woke to Narcan - aspirated pupils reactive

NEURO
__abnml serial 7's / inattentive / memory loss
__disoriented to time / place / person
__abnml response to commands
no response eyes open slow inappropriate
__abnml response to pain
withdraws flexor extensor none
__dysarthria / aphasic expressive receptive
__facial palsy forehead involved spared
__tongue deviation (to R / L)

higher functions
__cognition nml
__oriented x3
__no evidence of acute CVA

cranial nerves-
__nml as tested

cerebellar-
__nml as tested
__abnml Romberg / gait / finger-nose test
__abnml gait / ataxia

sensorimotor-
__sensation nml
__motor nml
__reflexes nml
__weakness / hemiplegia / dyspraxia
s Narcan - equal grips
__pronator drift
__altered light-touch / pin-prick / 2-pt discrimin
__tremor / abnml movements
__Babinski reflex
__asterixis

PSYCH

mental status
__appearance nml
__kinetics nml
__mood / affect nml
__speech nml
__thought content nml
__thought process nml
__judgment / insight
__disheveled / poor eye contact
__increase / decrease psychomotor
__depressed / tearful / anxious / paranoid
__labile / flat / agitated
__non-communicative / pressured / slow
__rambling / tangential Slurred S dentist
__suicidal / homicidal ideation / plan
__grandiosity / hallucinations vis / aud
__thought blocking / loose associations
__disorganized / flight of ideas
__poor insight / poor judgment

HEENT
__head atraumatic
__PERRL 3 - reactive
__visual fields nml
__EOM's intact
__ENT inspection nml
__oropharynx nml
__tenderness / swelling / ecchymosis
__raccoon eyes / Battle's sign
__scleral icterus / pale conjunctivae
__unequal pupils R ___mm L ___mm
__abnml funduscopic / papilledema
__EOM palsy / nystagmus
__TM blood
__depred gag reflex / handles secretions poorly
__dry membranes
__pharyngeal erythema / dental decay / exudate

NECK
__supple
__non-tender
__cervical lymphadenopathy
__stiff neck / meningismus
__carotid bruit
__Kernig's sign / Brudzinski's sign

RESPIRATORY
__no resp. distress
__breath sounds nml
__respiratory distress
__wheezes / rales rhonchi occas

CVS
__reg. rate & rhythm
__heart sounds nml
__tachycardia / bradycardia / irreg. irreg. rhythm
__JVD present
__murmur grade ___/6 sys / dias
__gallop (S3 / S4)
__decreased pulse(s)

ABDOMEN / GI
__non-tender
__no organomegaly
__guarding / tenderness
__hepatomegaly / splenomegaly / mass
mid line scar

EXTREMITIES
__non tender
__nml ROM
__no pedal edema
__tenderness
__pedal edema
__Homan's sign
(B) AKA

SKIN
__color nml, no rash
__warm, dry
__cyanosis / diaphoresis / pallor / ecchymosis
__rash / embolic lesions
__decubitus

LABS, EKG & XRAYS

**Normal lab value ranges are included on the original lab report*

CBC	Chem				UA
nml except	nml except	AST	PT		nml except
WBC	Na	Alk Phos	INR		
Hgb	K	Ammonia	PTT		
Hct	Gluc	TSH	Blood Tox		Preg Test + -
platelets	BUN	T4	ASA		Urine Tox
segs	Creat	D-Dimer	APAP		(circle)
bands	HCO3	Lactate	BAL		cocaine / PCP
			TCA		amphetamine
					opioids / THC

ABGs FIO_2 ____ /RA pH ____ pO2 ____ pCO2 ____
CSF clear xanthochromia bloody prot ____ gluc ____
WBC ____ PMN ____ lymph ____ RBC ____

EKG *Interp by ED provider* Rate ____ __NSR __A-fib ____
__nml intervals __nml axis __nml QRS __non-specific ST/TW changes
diagnosis __nml __abnml

CXR *interpreted by ED provider unless noted otherwise*
__nml / NAD __no infiltrates __nml heart size __nml mediastinum
Old CXR- __unchanged date: ____

CT Scan / MRI *brain* ____ *contrast / non-contrast*
nml / NAD

PROGRESS

☐ *see additional template: # 94 Sto* ____

Time ____ unchanged improved re-examined
PT consistently responds to Narcan bolus - Poison control consulted ☐ not well maintained on drip
☐ patient ambulating / mentating at pre-event baseline ____
Discharge VS: BP ____ HR ____ RR ____ Temp ____
__Dr ____ called at ____ Ret. call ____
will see patient in: ED / hospital / office

Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up
__prior records ordered
☐ Rx given

Additional history from:
family caretaker paramedics
__holding orders written

CRITICAL CARE *(excluding time for other separate services)*
TIME ☐ *30-74 min* ☐ *75-104 min* ____ *min*

CLINICAL IMPRESSION

ALTERED MENTAL STATE	Insulin Reaction *Hypoglycemia*
COMA	Meningitis
DELIRIUM	Overdose *Hypnotic / Narcotic*
Alcohol Intoxication	Seizure *post-ictal*
Carbon Monoxide Intoxication	Sepsis
Cerebrovascular Accident	Status Epilepticus *non-convulsive*
Hepatic Encephalopathy	Subarachnoid Hemorrhage
HHNC	Subdural Hematoma
Hypernatremia / Hyponatremia	Uncal Herniation
Intracranial Hemorrhage	

(3) UTI - possible sepsis
(8) Possible Opioid effects
Present On Admission *decubitus / UTI w/ foley*

Disposition Order Time
DISPOSITION- ☐ home ☐ admitted ☐ OBS ____
☐ AMA *(see AMA template #73)* ☐ transferred ____
Time Completed ____
CONDITION- ☐ unchanged ☐ improved ☐ stable ____
Care transferred to ____ MD / DO / MLP Time: ____
____ *NP / PA IDX Provider #* ____

☐ I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan and disposition.

MD / DO IDX Provider # ____
☐ Template Complete ☐ Dictated Addendum

Altered Mental Status-45

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

ER 724-045 Rev. 07/09 Pg 2 of 2

G013321377
2 - Healthcare Informa...
DOB 2 - Health... M AGE: 90
02/09/11 ER
M0102440

TEAMHealth Version 2.0 - 2008

51a **Procedures / Critical Care Add-on**

PROCEDURAL SEDATION NOTE

☐ See Nursing notes for V/S monitoring

Sedation type: deep moderate other_____

HPI ☐ see patient template

Indications: _____

last meal _____ Time: _ _ _ _

Past Hx ☐ see patient's template

prior complications to general anesthesia_____

prior complications to procedural sedation_____

Allergies __NKDA see nurses note _____

brevital etomidate fentanyl ketamine lidocaine

midazolam morphine nitrous oxide propofol_____

other_____

ASA Classification ____

E. Emergent conditions applies

P1. Normal healthy patient

P2. Patient with a mild systemic disease

P3. Patient with a severe systemic disease

P4. Patient with a severe systemic disease that is a constant threat to life

P5. Moribund patient who is not expected to survive w/o the operation

Physical Exam ☐ see patient's template

AIRWAY

__nml anatomy

__obese

__large tongue / teeth

__angioedema

__abnormal rule 3-3-2 rule

__possible upper airway obstruction

__neck immobility

Mallampati Classification ____

Class1. Soft palate, anterior / posterior tonsillar pillars, and uvula visible

Class2. Tonsillar pillars and uvula hidden by base of tongue

Class3. Only soft palate visible

Class4. Soft palate not visible

Preparation

__plan explained: _____

to patient to parent / guardian

__consent signed (see hospital consent)_____

__oximetry during procedure_____

__capnometry during procedure_____

__IV access obtained_____

__suction immediately available_____

__cardiac monitor used_____

Sedation

__versed_____

__etomidate_____

__propofol_____

__fentanyl_____

__ketamine_____

Reversal

__none_____

__narcan_____

__romazicon_____

Complications during / after procedure-

none vomiting apnea O_2 desaturation required BVM-PPV hypotension agitation other_____

Post Sedation Recovery Score ☐ see sedation record

I personally performed ☐ sedation and / or ☐ procedure

Intra-service time: __30 min or less __31-45 min __46-60 min

INTUBATION NOTE - Supervised Medic for intub

Airway Evaluation abnormal 3-3-2 rule obese large tongue large / loose teeth copious secretions

Mallampati Class: 1 2 3 4 5

Pre-tx __100% O_2 other_____

Induction __etomidate ✓midazolam __propofol

other:_____

Paralyate ☐ no contraindications to succinylcholine

✓rocuronium __succinylcholine K=5.2

other_____

Equipment ✓ETT / LMA size _____

__Glidescope / McGrath __Bougie_____

other_____

Post-intubation management: after ETT passed pt vomited prior to balloon inflation

ETT primary tube confirmation

__capnometry: __mm Hg ✓CO_2 change

✓direct visualization ✓chest rise

__tube in good position on CXR

__tube repositioned and re-confirmed with CXR

Vent settings: ☒ per Respiratory Therapy

Mode: CMV AC SIMV PS CPAP_____

Settings: TV 550 FIO_2 100 R 16 PS____ PEEP____

Ventilator sedation: propofol drip / other

Additional Notes: - family aware of possible aspiration

Pt woke c repeated doses of Narcan, Addison's reg, pt asked if he wanted intub if life saving and condition reversible = pt clearly stated in front of family he wanted intubation if reversible.

CENTRAL LINE

__CDC Sterile insertion guidelines followed_____

__2% chlorhexidine prep_____

__local anesthetic: lidocaine 1% / 2% ____mL _____

bupivacaine 0.25% / 0.5% ____mL _____

catheter_____Fr single / triple lumen PreSep_____

location: R / L U/S guided IJ subclavian supraclavicular supraclavicular brachial femoral_____

complications: none_____

CXR post-procedure:_____

TIME OUT called at: _ _ _ _ for_____

TIME OUT called at: _ _ _ _ for_____

TIME OUT called at: _ _ _ _ for_____

NP / PA IDX Provider # _ _ _ _ _

MD / DO IDX Provider # _ _ _ _ _

☐ Template Complete ☐ Dictated Addendum

Grays Harbor Community Hospital

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

G013321377

2 - Healthcare Informat...

DOB 2 - Health... M AGE: 90

02/09/11 ER

M0102440

ER 724-51a Rev. 07 / 09 Pg 1 of 2

TEAMSystem Version 2.0 - 2008

02/10/11

02/10/11

Early Goal Directed Therapy

__fluid resuscitation to CVP of _____ mmHg (8-12)
__vasopressors for MAP < 65 mmHG (SBP < 90)
. norepinephrine vasopressin dopamine
__steriods: *hydrocortisone*_____
__endotracheal intubation for $ScVO_2$ < 70%_____
__transfusion to Hct ≥ 30%_____
__dobutamine infusion for $ScVO_2$ < 70%_____
__final $ScVO_2$: _____% _____
__antibiotics (< 3hrs) _____

LP

__discussed risks, benefits, alternatives; __parent/guardian consents
sitting / lying
betadine prep fluid color_____RBC_____WBC_____
sterile technique glucose_____polys_____lymph_____
L3-4 L4-5 protein_____monos_____gm stn _____

ARTERIAL LINE

__CDC Sterile insertion guidelines followed_____
__2% chlorhexidine prep_____
__local anesthetic: *lidocaine 1% / 2%* _____mL _____
bupivacaine 0.25% / 0.5% _____mL _____
catheter_____Fr *U/S guided blind*_____
location: R / L _____

CARDIOVERSION

__Procedure discussed with Patient / Guardian and consent obtained.
*Time*_____ unchanged improved re-examined
__cardioverted at_____J
__post cardioversion rate_____
__post cardioversion rhythm_____
__NSR __afib __aflutter __V-tach __V-fib

CHEST TUBE

chest tube inserted (_____*French*) *Betadine prep*
anesthesia: _____mL *local lidocaine / marcaine /* _____
position: *mid / anter / post axillary line* _____ *interspace*
sutured in place *position confirmed on CXR*
return: *air / blood* _____ *connected to suction*

Wound Description / Repair

length_____cm location_____
linear stellate irregular flap into: subcut / muscle
clean contaminated *moderately / heavily* _____
distal NVT: neurovascular intact no tendon injury
anesthesia: local digital block topical _____ lidocaine
marcaine epi / bicarb _____mL
prep: Shur-Clens / Hibiclens
irrigated w/ saline *extensively cleaned* debrided *mod. /extensive*
wound explored wound margins revised
to bone / in bloodless field multiple flaps aligned
no foreign body identified _____
foreign material removed *required instrumentation / extension*
repair: *Wound closed with: Dermabond / steri-strips*_____
SKIN- #_____ _____-0 nylon / prolene / staples_____
SUBCUT- #_____ _____-0 vicryl /_____
OTHER - #_____ _____-0 _____

FRACTURE / DISLOCATION / REDUCTION / SPLINTING

Location:_____
Sedation: *see procedural sedation / local block / regional block / joint / fracture block / betadine prep / sterile procedure*_____
Anesthetic: lidocaine / bupivacaine / EPI 0.25% 0.5 % 1% 2%
amount of anesthetic:_____mL
Pre-procedure DNVT status: *see Physical Exam*_____
Technique:
*Traction - Counter Traction / Scapular Rotation / Hennepin / Stimson / Whistler / other*_____

Post-procedure DNVT status
__*normal* _____
__unchanged from pre-procedural baseline _____
__no compartment syndrome thought to be present_____
__other_____
Post reduction imaging
__deformity is completely reduced_____
__deformity is acceptably reduced_____
__deformity is unacceptably reduced_____
Splint type: *Velcro / Fiberglass / Plaster / Aluminum-foam / metal Volar / Extensor / Thumb spica / Sugar tong / Gutter stirrup / Posterior Ace Wrap / Boot orthosis / Air splint / Buddy tape / long / short*_____
splint location:_____
applied by: *Provider RN Tech*_____
Provider post-splinting NVT check & splint application check:
splint in good position & NVS normal_____
other_____
other_____

TIME OUT called at: _____ for_____
TIME OUT called at: _____ for_____
TIME OUT called at: _____ for_____

_____ *NP / PA IDX Provider #* _____
_____ *MD / DO IDX Provider #* _____
☐ Template Complete ☐ Dictated Addendum

Critical Add-on - 51a

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PROVIDER RECORD

M.EDMDTS

ER 724-51a Rev. 07 / 09 Pg 2 of 2

G013321377
2 - Healthcare Informati...
DOB 2 - Healthcar... AGE: 90
02/09/11 ER
M0102440

TRAUMAtha Version 2.0 - 2009

MD 2011-153821-000111

NIGHTSHIFT RADIOLOGY

*** Preliminary Report ***

Gray's Harbor Community Hosptial

CT HEAD

Patient: 2 - Healthcare Information Re...

MR #: M0102440

Exam Date: 02/09/2011

Radiologist: Brad Tipler, M.D.

Physician contact number regarding this report:

Voice (866) 832-5834

Physician number listed is to only be used on the date of this report – for all other times or issues, please call the main business number at (866) 316-8900

HISTORY: Decreased level of consciousness.

HEAD CT: The bones and extracranial structures are unremarkable. Within the cranium no extra-axial mass or fluid collection is seen. There is no acute hemorrhage.

The ventricles and sulci are prominent. The white matter shows inhomogeneous areas of decreased density. There is no focal mass effect or focal lesion.

IMPRESSION: Moderate atrophy and white matter findings consistent with chronic changes. No acute intracranial process demonstrated.

This report was transmitted to the emergency room at 2/9/2011 2:50:00 AM PST.

***This report constitutes a preliminary interpretation only. Non acute findings felt to be unrelated to the clinical presentation may not be discussed in this report. The study will be interpreted and a final report will be generated by the local Radiologist the following shift.

***INTERPRETING RADIOLOGIST: If there is a significant discrepancy between this report and your interpretation please *fill out and send the NightShift Discrepancy Form.*

2/9/2011 00:34:01
90 Years Male

GHCH EMERGENCY DEPARTMENT

02/10/11

Room: ER5
Oper: NLE

C0133213377

2 - Healthcar...

2 - He...

DOB M AGE: 90
02/09/11 ER

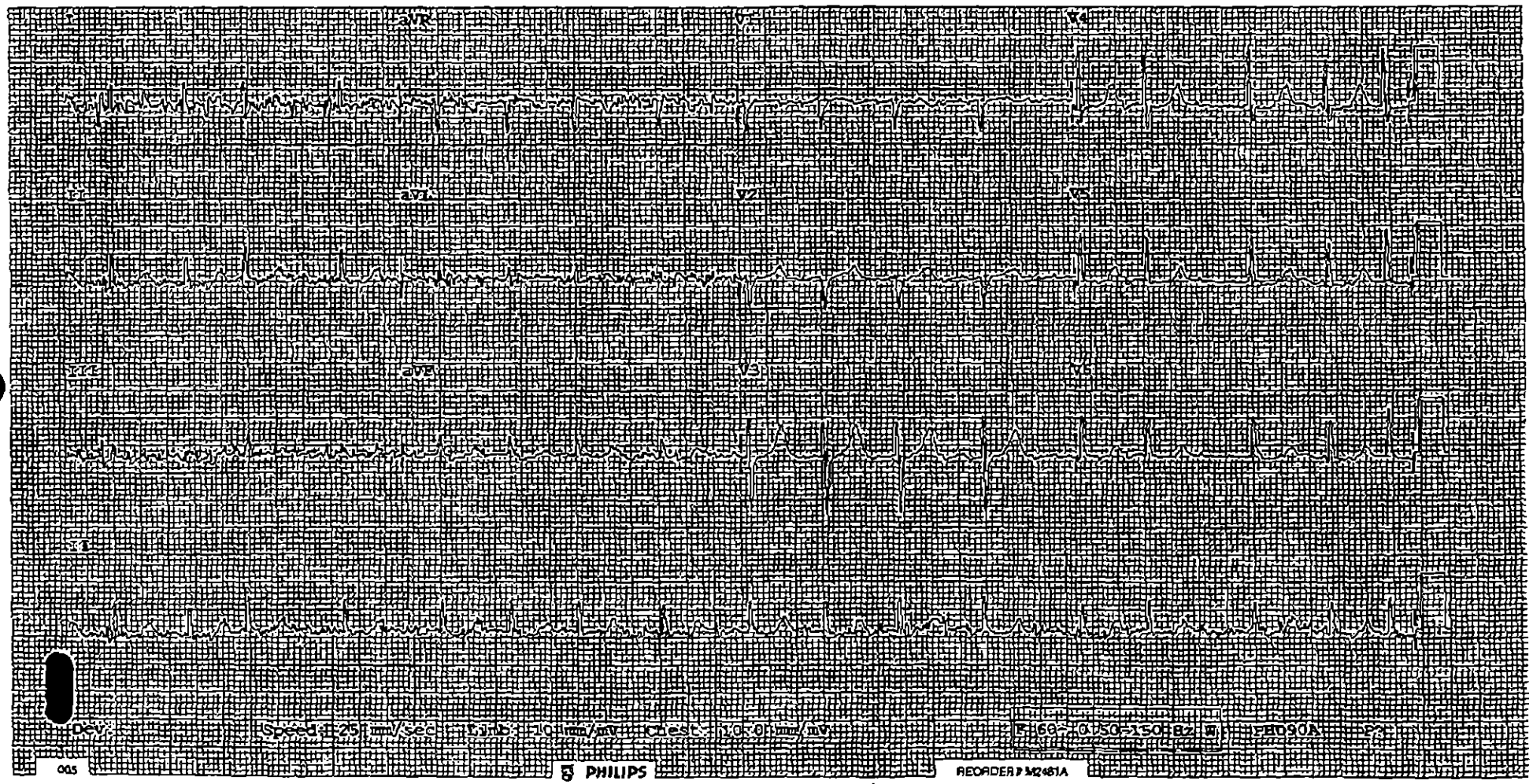
M0102440

Rate 102 . ATRIAL FIBRILLATION, V-RATE 77-136
. CONSIDER ANTERIOR INFARCT
PR . ARTIFACT IN LEAD(S) I,II,III,aVR,aVL,aVF,V1
QRSD 94
QT 376
QTc 490

--AXIS--
P
QRS 63
T 17

- ABNORMAL ECG -

Unconfirmed Diagnosis
COPY



TIME:	DATE:	
	ORDERS	**RESULTS**
	☐ FHT	BPM _____ _____ (init)
	☐ Orthostatic VS _____	
		Supine BP _____ P _____ _____ (init)
		Sit BP _____ P _____ _____ (init)
		Stand BP _____ P _____ _____ (init)
	☐ Fingerstick Glucose _____	_____ mg/dl
	☐ Visual Acuity:	OS ____ OU ____ OD ____ _____ (init)
	☐ Urine Pregnancy _____	+ _____ – _____ _____ (init)
	☐ Urine Dip (Refer to urine slip)	_____ (init)
	☐ Gastroccult + – _____	_____
	☐ Hemoccult + – _____	_____ _____ (init)
	☐ ISTAT ☐ TROPT ☐ ABG ☐ CHEM 8	_____ (init)
0250	Narcan 0.4 mg IVP x 1 – late entry	Dunoff
	Narcan drip – start @ 0.4 mg/hr – titrate to rousable & voice, MAP > 60, sat > 92% on 2L RR > 10	
	Ceftriaxone 1g IV x 1	✓
0320	NS 500 ml IV x 1	✓
0410	~~Unasyn 3.375g IV x 1~~	✓ error
0415	2.0 Syn 3.375g IV x 1	
	Allergies: Bactrim / Clindamycin	
	Physician / Mid-Level Signature:	

Grays Harbor COMMUNITY HOSPITAL
Aberdeen, WA 98520

M.EDMDORD

Emergency Dept.

Physician Orders

ER723-602 (11/02/10)

PATIENT LABEL

G013321377

2 - Healthcare Informa... 2 - Healthc...

DOB M AGE: 90
02/09/11 ER

M0102440

02/10/11

Is the patient pregnant? Yes No NA (Circle)	Is the patient lactating? Yes No NA (Circle)	Patient Ht: ft/inches Patient Wt: kg Actual
Source of Information: ☐ Patient ☐ Other (verbal), who ☐ Printed list ☐ Medication bottles or containers Pharmacy used: Pharmacy phone number:	ALLERGIES/REACTION (Include food, medication, substances, etc). ☐ (No Known Drug Allergies) 1 Bactrim 2 Clindamycin 3 4 5 6 7 8	

PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING:
Include any over the counter medications (i.e. Tylenol, Tums), and any Herbal and Diet supplements (i.e. Ginko, Garlic) and/or recreational substances.

☐ CHECK BOX IF: Patient not taking medications, diet or herbal supplements or over the counter meds.
☐ Unable to Obtain Medication history (due to condition or unavailability of reliable source of information)
☑ Patient from Skilled Nursing Facility, See Attached Medication Lists (Fax list to pharmacy)

Name of Medication & Dose	Route Circle or fill in blank	How often taken Circle or fill in blank	Last dose taken (date; i.e. this a.m.)
25	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	
	PO / Inh /	Daily / ___ X Day / HS /	

Update: ___ Sig: ___ Update: ___ Sig: ___
Update: ___ Sig: ___ Update: ___ Sig: ___

☐ Copy of Medication History and Reconciliation given to patient on discharge (ER only)

History Reviewed by: ___ RN Date ___ Time: ___
History Revised by: ___ RN Date ___ Time: ___

Glens Harbor Community Hospital

M.MEDREC

MEDICATION HISTORY AND RECONCILIATION

NU872-601 (12/09)

PATIENT LABEL

G013321377

2 - Healthcare Informatio...
DOB 2 - Health... M AGE: 90
02/09/11 ER

M0102440

02/10/11

12 General Medicine Complaints

TIME TO ROOM: 0025 ROOM: 5

TRIAGE TIME 0025 ESI 1 2 (3) 4 5

NAME:
D.O.B: AGE: M / F
HISTORIAN: patient paramedics family
ARRIVAL MODE: car [3]EMS[3] police
PCP: none
^IMMUNIZATIONS: current / referral
flu pneumovax

TREATMENT PTA see EMS report IV O_2
last blood glucose ★ ASA

VITALS Weight kg
BP / P RR temp TM O R Ax
SaO_2 RA / O_2

PAIN LEVEL current: 0 /10 max /10 acceptable /10
scale used quality location

CHIEF COMPLAINT
started hrs / days ago. ↓ LOC
[3]direct admit via ED[3]

high blood pressure
shortness of breath
cough dry productive
chest pain
nausea / vomiting x
abdominal pain
chemical exposure
high / low blood sugar
fever / chills
problems urinating
back pain
diarrhea
headache

ALLERGIES NKDA Clinda
drug - PCN / ASA / sulfa / latex / codeine / iodine
food -

MEDS none see med list

PAST MEDICAL HX negative
heart disease HTN diabetes: insulin PVD UTIs BHP
past surgeries none GERD, ?GI Bleeding
B/L AKA

SOCIAL HX
★ have you smoked in past 12 months n/a counseling performed
drug / alcohol
^TB exposure / symptoms
^has been physically hurt or threatened by someone close
fall risk screen completed ★ Fall risk

LNMP G P Ab pregnant / postmenop / hyst

RN Signature

[1]INITIAL ASSESSMENT[1] TIME: 0025

GENERAL APPEARANCE
no acute distress
alert
mild / moderate / severe distress
anxious / decreased LOC

^FUNCTIONAL / NUTRITIONAL ASSESSMENT
independent ADL
appears well
nourished / hydrated
assisted / total care
obese / malnourished
recent weight loss / gain

RESPIRATORY
no resp distress
nml breath snds
mild / moderate / severe distress
wheezing / crackles / stridor
decreased breath sounds

CVS
regular rate
pulses strong & equal
skin warm & dry
skin intact
tachycardia / bradycardia
pulse deficit
cool / diaphoretic
pale / cyanotic
skin breakdown

NEURO
oriented x 3
PERRL
disoriented to person / place / time
confused
pupils unequal R 4 L 4
weakness / sensory loss

EENT
nml eye inspection
nml ENT inspection
scleral icterus / pale / red conjunctivae
nasal drainage
epistaxis

ABDOMEN
nml inspection
soft, non-tender
bowel sounds nml
tenderness / guarding / rebound
rigid / distended
bowel sounds hyper hypo absent

EXTREMITIES
non-tender
moves all extremities
no pedal edema
calf tenderness
limited ROM / contractures
pedal edema

ADDITIONAL FINDINGS

INITIAL ACTIONS

TIME			INIT
0A	ID band applied	ID band verified	
	disrobed / gowned	blanket provided	
	bed low position	side rails up x1 x2	
	call light in reach	head of bed elevated	

Nurse Signature

^ protocol available ★ core measures for Pneumonia / AMI

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT NURSING RECORD

G013321377
2 - Healthcare Informa...
DOB 2 - Healt... M AGE: 90
02/09/11 ER
M0102440

MEDNUTS BR724-A Rev. 07/09 Patient Label NURSING 10/11

02/10/11

ACTIONS

TIME		INIT
OA	cardiac monitor / ★ pulse oximeter O_2 4 L via NC / mask / NRB	
	Accu-Chek	
	emesis / incontinence care	
0045	ready for Dr eval. notified doctor / seen by Dr	
	restraints see documentation Byrd	
	social worker intervention limited extended	

IV STARTS lock / IV fluid

TIME	#	site	gauge	attempts	complications	INIT
PTA	1	(R) H	18			EMS
0345	2	(R) AC	20			

IV / MEDICATION INFUSION RECORD

Start Time	Solution / Med	Type / Pump	Rate ml / hr	Stop Time	Amount Infused	INIT
PTA	NS TKO	KVO			1000	EMS
	Response: no change improved					
0145	A'd IVF to w/o Bolus					
	Response: no change improved					
0220	Norcuron drip ✓ 25mg (0.4 mg/ml) in 24 hrs of NS					
	Response: no change improved					

(Charted on page 2 cont'd)

MEDICATIONS

★ ASA / beta-blockers / antibiotics / thrombolytics / pneumovax

Time	Medication	Dose	Route	Site	INIT
0148	Norcuron	0.4mg	IV	—	
0150	Response: no change improved				
0255	Norcuron	0.2mg	IV	—	
0311	Response: no change improved				
0315	Ceftriaxone 1gm IV Piggyback				
	Response: no change improved RAC				
0330	Norcuron	0.4mg	IV		
	Response: no change improved from new bag				
0535	Norcuron	0.4mg	IV		
	Response: no change improved from new bag				

immunizations / OTC / prescription PO / SL / TOPICAL / parenteral meds / blood products / "crit care med"

PROCEDURES

TIME		INIT
0030	12-lead EKG performed notified Byrd	
0045	Foley 14 Fr. 150 mL return	
	NG 18 fr. mL return coffee ground	
	placement confirmed to suction low / intermittent	
PTA	lab drawn / sent by ED tech / nurse / lab	EMS
	clean catch / urine pregnancy test results back	
	★ ABG drawn by nurse / MD / RT	
0040	★ blood Cx drawn 0050 x2	
	awaiting physician review	
0055	to Xray single multi w/ monitor / nurse / O_2 / tech	
	return to room	
0210	to CT w/ monitor / nurse O_2 tech	
0225	return to room	
	★ to cath lab for PCI / other	

VITAL SIGNS

TIME	BP	P	RR	T	SaO_2	GCS	Pain	Pupils	INIT
0045	93/72	100	19	x	96%	sleeping	10		
0110	94/66	88	19	x	94%	"	10		
0145	90/39	82	12	x	85%	sleeping	10		
2152	95/55	83	18	x	98%	sleeping	10		
0200	109/63	92	16	x	99%		10		

ADDITIONAL NOTES

0145 - Dr. Byrd in for rev - pt. LOC ↓, unresponsive to verbal / painful stimuli

0150 - pt. more responsive - SpO2 ↑ 96% - called supervisor for Narcan drip

0210 - 110/66 78, 16 95%

INTAKE 1600 1700 OUTPUT 250

__IV / saline lock discontinued: Total Amt Infused ____ Time ____ Initials ____

PROPERTY TO:

__patient __family __security __safe __see patient belongings list

DISPOSITION

__discharged home police nursing home ME funeral home

__verbal / written instructions / RX given to: patient ____

__verbalized understanding

__learning barriers addressed ____

__accompanied by / driver ____

✓ admitted / transferred to CCU 5

__report to Sally time 0424

__transfer documentation completed

__notified family / police / ME ____

__left AMA / LWBS signed AMA sheet refused ____

__physician notified of: ____

Discharge Vitals

BP ____ HR ____ RR ____ Temp ____ SaO_2 ____

__pain level at discharge ____/10

CONDITION

__unchanged __improved __stable __other ____

Depart Time 0450 Mode: walk crutches W/C stretcher ambulance

Discharge Nurse Signature ____

☒ Continuation Sheet x 2 ☐ Highest E / M Level

SIGNATURE	INITIAL

General Medicine Complaints - 12

* protocol available ★ core measures for Pneumonia / AMI

EMERGENCY DEPARTMENT NURSING RECORD

M.EDNUTS

BR724-162 Rev. 07/09 Pg 2 of 2

G013321377

DOB 2 - Health... M AGE: 90

02/09/11 ER

M0102440

30 Vitals Continuation / Additional Notes

VITAL SIGNS

TIME	BP	P	RR	T	SaO_2	Rhythm	Pain	Pupils	INIT
0220	116/60	85	18	X	99%	SR	5/10		
0245	91/53	72	18	X	94%	SR	4/10		
0255	81/49	75	14	X	91%	SR	3/10		
0305	124/71	82	18	X	98%	SR	/10		
0320	113/66	80	18	X	98%	SR	3/10		
0325	91/56	90	20		98%	SR	/10		
0330	97/60	80	20		97%	SR	/10		
0340	117/70	88	18		95%	SR	/10		
0350	133/73	87	22		98%	SR	/10		
0355	173/88	100	20		100%	SVT	/10		
0405	150/76	91	28		100%	Vent	/10		
0410	117/59	80	18		100%	Vent	/10		
0415	109/58	74	18		100%	Vent	/10		
0430	124/64	89	18		100	Vent	/10		
0440	108/58	84	18		100%	Vent	/10		

ADDITIONAL NOTES ☐ *continued from template*

0215 - pt's resp. status unchanged - maintaining SpO2 in 90's c 99% = BP: 121/66
0225 Returned from CT Narcan gtt 4 mg/hr 250 mL NSS 16 mcgs/mL Precedex running @ .25 mcg/kg/hr 0.4 mg/hr
0255 ↑ Narcan drip to 0.8 mg/hr (50 mL/hr)
0300 - pt. easily awakened to verbal stimuli.
0305 - Report given over to Lance, RN
0320 NS 500 mL IV W.O.
Pt D/C back to Oxy mask 5L. Pt breathing thru mouth mainly
0330 Narcan
0335 Pt given Narcan bolus for ERP to take. Pt per wishes. Pt easily aroused & talking & ERP. Pt states he would want tube intubated. "The tube is how I'll get better"
0340 Narcan gtt stopped for intubation
0345 RT at bedside
0353 Bite block placed (+) color change 24cm at the lip. Bilat = equal breath sounds
0355 NS 500 bolus infused
0358 16F OG placed, (+) auscultation Bowel sounds
Vent better 18 bpm TV 500 ov 100%
0400 Post Xray Chest taken
0416 N.H. Notified of admit

SIGNATURE	INITIAL

Grays Harbor Community Hospital

EMERGENCY DEPARTMENT NURSING RECORD

G013321277

2 - Healthcare Informati...

2 - Health...

M AGE: 90

02/09/11 ER

M0102440

M.EDNUTS

ER724-180 Rev. 07/09 Pg 1 of 2

NURSING [redacted] 10/11

MD 2011-153821-000118

02/10/11

MEDICATIONS

Time	Medication	Dose	Route	Site	INIT
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				

Vitals Continuation / Additional Notes- 30

ADDITIONAL NOTES ☐ continued from template

SIGNATURE	INITIAL

Grays Harbor
COMMUNITY
HOSPITAL

M.EDNUTS

EMERGENCY DEPARTMENT NURSING RECORD

ER724-180 Rev. 07/09 Pg 2 of 2

G013321377
2 - Healthcare Informati...
DOB 2 - Healthc... M AGE: 90
02/09/11 ER
M0102440

Medical Continuation Sheet

[4]REASSESSMENT[4] DATE_____TIME_____

GENERAL APPEARANCE
__no acute distress __mild / moderate / severe distress
__alert __anxious / decreased LOC

RESPIRATORY
__no resp distress __mild / moderate / severe distress
__nml breath snds __wheezing / crackles / stridor
__decreased breath sounds

CVS
__regular rate __tachycardia / bradycardia
__pulses strong __pulse deficit
__skin warm & dry __cool / diaphoretic
__pale / cyanotic

NEURO
__oriented x 3 __disoriented to person / place / time
__PERRL __confused
__pupils unequal R_____ L_____
__weakness / sensory loss

EENT
__nml eye inspection __scleral icterus / pale / red conjunctivae
__nml ENT inspection __nasal drainage
__epistaxis

ABDOMEN
__nml inspection __tenderness / guarding / rebound
__soft, non-tender __bowel sounds hyper hypo absent
__bowel sounds nml

EXTREMITIES
__non-tender __calf tenderness
__moves all extremities __limited ROM
__no pedal edema __pedal edema

ADDITIONAL FINDINGS

ACTIONS / PROCEDURES

TIME		INIT
	"Active Time Out" (Verified with MD / RN)	
	☐ 1. Pt. ID verified with identifiers	
	☐ 2. Correct Procedure, Equipment and Position Verified	
	☐ 3. Correct Site Verified	
	assisted with [cc]intubation[cc] ETT #	
	placement verified by: CXR auscultation	
	[cc]transvenous pacemaker insertion[cc]	
	[cc]ventilator[cc] TV_____ rate_____ FIO_2_____	
	[cc]cardioversion[cc]	
	[cc]CPR[cc] see flow sheet	
	[4]NG[4] fr. mL return	
	placement confirmed to suction low / intermittent	
	[3]Foley[3] fr. mL return	
	[5]gastric lavage[5] irrigated with mL	
	pill fragments seen	
	[5]activated charcoal[5] w/ sorbital route	
	assisted with [5]central line[5] placement	
	assisted with [cc]chest tube[cc] insertion fr. site	
	bronchodilator treatment nebulizer inhaler	
	x [3]1[3]	
	x [4]2[4]	
	x [6]3[6]	
	[5]warming[5] / [5]cooling measures[5]	
	type	
	[5]restraints[5] see documentation	

VITAL SIGNS

TIME	BP	P	RR	T	SaO_2	Rhythm	Pain	Pupils	INIT
							/10		
							/10		
							/10		
							/10		
							/10		
							/10		
							/10		
							/10		
							/10		

IV STARTS [5]lock[2] [4]IV fluid[4]

TIME	#	site	gauge	attempts	complications	INIT

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT NURSING RECORD

G013321377

2 - Healthcare Inform...

DOB 2 - Healt... 11-AGE: 90

02/09/11 ER

M0102440

M.EDNUTS

ER724-161 Rev. 07/09 Pg 1 of 2

IV / MEDICATION INFUSION RECORD ⁵blood products⁵ ⁶⁶crit care med⁶⁶

Start Time	Solution / Med	Type / Pump	Rate ml / hr	Stop Time	Amount Infused	INIT
0350	NS 500	TKO				LS
	Response: no change improved					
0405	Propofol gtt	5mcg/kg/min				LS
	Response: no change improved					
0420	Zosyn 3.375 Gravity	[illegible]	200			[illegible]
	Response: no change improved					

MEDICATIONS

Time	Medication	Dose	Route	Site	INIT
0351	Versed	1mg	IV	RAC	LS
	Response: no change improved				
0352	Vecuronium	10mg	IV	RAC	LS
	Response: no change improved				
0355	Versed	1mg	IV	RAC	LS
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				

¹immunizations¹ ²OTC² ³prescription PO / SL / TOPICAL³
⁴parenteral meds⁴ ⁵blood products⁵ ⁶⁶crit care med⁶⁶

⁴IV DRIP INFUSIONS⁴

Start Time	Solution / Med	IVPB	Rate ml / hr	Stop Time	Amount Infused	INIT

TIME	BP	HR	RR	PAIN	RATE	DOSE	INITIAL

Start Time	Solution / Med	IVPB	Rate ml / hr	Stop Time	Amount Infused	INIT

TIME	BP	HR	RR	PAIN	RATE	DOSE	INITIAL

Start Time	Solution / Med	IVPB	Rate ml / hr	Stop Time	Amount Infused	INIT

TIME	BP	HR	RR	PAIN	RATE	DOSE	INITIAL

Medical Continuation Sheet - 11

CONSULTS

Time called	Service	Time in ED

ADDITIONAL NOTES ☐ *continued from template*

INTAKE **OUTPUT**

IV:	Urine:
PO:	Emesis:
Other:	Blood-Approx:
Total:	Total:

SIGNATURE	INITIAL
	LS

☐ Highest E / M Level

Grays Harbor COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT NURSING RECORD

M.EDNUTS

ER724-161 Rev. 07/09 Pg 2 of 2

G013321377
2 - Healthcare Inform...
008
2 - Health...
AGE: 90
02/0 /11 ER
M0102440

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

PATIENT: 2 - Healthcare Information Readily... ACCT #: G013321377 LOC: 3RD U #: M0102440
AGE/SX: 90/M ROOM: 315 REG: 02/09/11
REQ DR: GIVENS,BARBARA L STATUS: DIS IN BED: 02 DIS: 02/14/11

**********CHEMISTRY**********

	2/11/11 0509	2/10/11 0525	2/9/11 2110	Reference	Units
Sodium	141	146 H		[136-145]	mEq/L
Potassium	3.5	3.8		[3.5-5.1]	mEq/L
Chloride	112 H	119 H		[96-107]	mEq/L
Bicarbonate	18 L	20 L		[22-31]	mEq/L
Anion Gap	15	11		[7-18]	
Glucose Random	161 H	71		[60-121]	mg/dL
Urea Nitrogen	31.0 H	34.0 H		[8.0-23.0]	mg/dL
Creatinine	1.3 H	1.3 H		[0.7-1.2]	mg/dL
GFR Est NonAfr	52(a) L	52(a) L		[SEE NOTE]	SEE NOTE
Calcium	8.4	8.1 L		[8.2-9.6]	mg/dL
Hemoglobin A1c			5.3	[4.8-5.9]	%
BNP			263 H	[Up to 50]	pg/mL

	2/9/11 2110	2/9/11 0040	2/8/11 2354	Reference	Units
Sodium	145		141	[136-145]	mEq/L
Potassium	3.5 D		5.2 H	[3.5-5.1]	mEq/L
Chloride	118 H		111 H	[96-107]	mEq/L
Bicarbonate	18 L		23	[22-31]	mEq/L
Anion Gap	13		12	[7-18]	
Glucose Random	92		291 H	[60-121]	mg/dL
Urea Nitrogen	37.0 H		40.0 H	[8.0-23.0]	mg/dL
Creatinine	1.2		1.2	[0.7-1.2]	mg/dL
GFR Est NonAfr	57(a) L		57(a) L	[SEE NOTE]	SEE NOTE
Ammonia		60		[27-102]	ug/dL
Magnesium			2.2	[1.6-2.4]	mg/dL
Calcium	7.9 L		9.0	[8.2-9.6]	mg/dL
Alb-adj Calcium			9.1		mg/dL
Total Protein			6.5(b)	[6.4-8.3]	g/dL
Albumin			3.9	[3.4-4.8]	g/dL
A/G Ratio			1.5	[1-1.8]	
Bilirubin Total			0.1 L	[0.2-0.9]	mg/dL
ALT			15	[10-44]	U/L
Alk Phosphatase			105	[40-129]	UL
AST			21	[10-34]	U/L
Creatine Kinase			28	[20-200]	U/L
Troponin T	0.02		< 0.01	[0.00-0.03]	ng/mL
TSH	1.11			[0.50-4.20]	uIU/mL

NOTES: (a) Reference range for eGFR is >59mL/min/1.73sq.meters.
This result is for non-African Americans. If patient is African-American, multiply by 1.21 for correct estimate.
(b) For recumbent patients: 6.0 - 7.8 is "normal."
Patients >60y may run about 0.2g lower.

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readi... #G013321377 (Continued)

CHEMISTRY continued

	2/9/11		2/8/11		
Date					
Time	2110	0040	2354	Reference	Units
Alcohol Serum			< 0.01(c)	[<0.01]	gm/dL

THERAPEUTIC DRUG MONITORING

	2/13/11			
Date				
Time	0820		Reference	Units
Vancomycin Tr	16.7(d)	H	[10-15]	ug/mL

NOTES: (c) Values up to 0.050 gm/dL are not indicative of alcohol intoxication.
(d) Higher trough concentrations of 15-20 ug/mL are recommended for nosocomial and ventilator-associated pneumonia or deep-seated staphylococcal infections.

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

**********BLOOD GASES & COOXIMETRY**********

Date	2/9/11					
Time	1815	0640	0423	Reference	Units	
Oxygen Delivery	VENT	VENT	VENT			
FIO2/VT/Rate?	35%T PIECE	70/550/18/5	100/500/18			
pH, Arterial	7.35	7.30 L	7.29 L	[7.35-7.45]		
PCO2	34	36	38	[32-45]	mmHg	
PO2	108 H	201 H	207 H	[75-100]	mmHg	
Bicarbonate	19	17 L	18	[18-20]	mEq/L	

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readily... #G013321377 (Continued)

**********DRUGS OF ABUSE SCREENING**********

Date	2/9/11		
Time	1815	Reference	Units
Benzo	NEGATIVE(e)	[()]	
Benzo Confirm	SEE NOTE(f)	[()]	
Drug Confirm	SEE NOTE(g)	[()]	

NOTES: (e) Performed by Quest Diagnostics
1737 Airport Way South, Suite 200, Seattle

(f)
THE SUBMITTED URINE SPECIMEN WAS TESTED AT THE LISTED CUTOFFS AND CONFIRMED BY A SECOND INDEPENDENT CHEMICAL METHOD.

DRUG CLASS	INITIAL TEST LEVEL
BENZODIAZEPINES	300 ng/mL

Test performed at QUEST DIAGNOSTICS-PORTLAND
6600 SW HAMPTON STREET
PORTLAND, OR 97223-8348
Director: JOEL M. SHILLING, MD

See also (e)

(g)
* Theee results are for medical treatment only. *
* Analysis was performed as non-forensic testing. *

See also (e)

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readily I... #G013321377 (Continued)

HEMATOLOGY

	2/11/11 0509		2/10/11 0525		2/8/11 2354		Reference	Units
WBC	10.4		6.9		16.1	H	[4.8-10.8]	thou/uL
RBC	3.70	L	3.75	L	4.28		[4.11-5.74]	mill/uL
Hemoglobin	12.0	L	11.9	L	13.5		[12.8-17.1]	g/dL
Hematocrit	34.8	L	35.5	L	41.0		[37.6-50.0]	%
MCV	94.2		94.6		95.9		[80.0-98.0]	fL
MCH	32.4	H	31.9	H	31.6	H	[27.0-31]	pg
MCHC	34.4		33.7		33.0		[32.0-36.0]	g/dL
RDW (aniso)	14.2		14.5		14.3		[11.5-14.5]	%
Platelets	155		142	L	238	D	[150-400]	thou/uL
MPV	8.9		9.0		9.1		[7.4-10.4]	fL
Neutrophils			72.8	H			[43-70]	%
Lymphocytes			13.2	L			[21-46]	%
Monocytes			6.4				[4-12]	%
Eosinophils			7.1	H			[1-4]	%
Basophils			0.5				[0-2]	%
Neutrophils Abs			5.1				[1.8-8.0]	thou/uL
Lymphocytes Abs			0.9	L			[1.0-4.8]	thou/uL
Monocytes Abs			0.4				[0.0-0.8]	thou/uL
Eosinophils Abs			0.5				[0.0-0.5]	thou/uL
Basophils Abs			0.0				[0.0-0.2]	thou/uL
Polys	90	H			79	H	[34-64]	%
Bands	2	L			9		[5-11]	%
Lymphs Normal	6	L			11	L	[23-44]	%
Monocytes	1	L			1	L	[3-6]	%
Eosinophils	1						[1-4]	%
Abs Neut (calc)	9.57	H			14.17	H	[1.80-7.70]	thou/uL
Plt Estimate	ADEQUATE				ADEQUATE			
Seg Neut(calc)	9.4	H			12.7	H	[1.8-7.0]	thou/uL
Band Neut(calc)	0.2				1.4	H	[0.0-1.0]	thou/uL
Lymphocyt(calc)	0.6	L			1.8		[1.0-4.8]	thou/uL
Monocytes(calc)	0.1				0.2		[0.0-0.8]	thou/uL
Eosinoph(calc)	0.1						[0.0-0.5]	thou/uL
RBC Morphology	NORMOCYTIC				NORMOCYTIC			
RBC Stain	NORMOCHROMIC				NORMOCHROMIC			

COAGULATION

	2/8/11 2354		Reference	Units
Protime	13.1		[11.3-14.6]	sec
INR	1.03(h)			

NOTES: (h) INR therapeutic range: 2.0-3.0
Prosthetic valves & recurrent systemic embolism: 3.0-4.5
WARNING: Heparin within last 2 hours of collection may cause a false elevation. (Not a problem with low-molecular weight heparins.)

Patient 2 - Healthcare Information Readily Id... Age/Sex: 90/M Acct#G013321377 Unit#M0102440

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

HEMATOLOGY continued...
COAGULATION continued...

	Date 2/8/11 Time 2354	Reference	Units
APTT	32	[23-37]	sec

Patient: 2 - Healthcare Information Readily... Age/Sex: 90/M Acct#G013321377 Unit#M0102440

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

**********URINALYSIS**********

Date	2/9/11		
Time	0045	Reference	Units
Collection	STCATH		
Color	STRAW		
Appearance	HAZY		
Spec. Gravity	1.020	[1.003-1.030]	
pH Urine	5.0	[5.0-8.0]	
Leuk. esterase	2+ Abn	[NEGATIVE]	
Nitrite	NEGATIVE	[NEGATIVE]	
Protein Screen	TRACE Abn	[NEGATIVE]	
Glucose Screen	NEGATIVE	[NEGATIVE]	mg/dL
Ketones	NEGATIVE	[NEGATIVE]	
Urobilinogen	NORMAL	[NORMAL-1]	mg/dL
Bilirubin Scrn	NEGATIVE	[NEGATIVE]	
Occult Blood	NEGATIVE	[NEGATIVE]	
White Bld Cells	1-5		/hpf
Red Blood Cells	NONE SEEN		/hpf
Epithelial Cell	RARE		/hpf
Bacteria	MODERATE		
Mucous	NONE SEEN		
Cult Indicated?	YES		

Test	Day	Date	Time	Result	Reference	Units
Drug Cut-offs	-4	FEB 12	1115	SEE BELOW(i)		

NOTES: (i) The following cut-off concentrations are established for the drug classes screened:

AMP	Amphetamines	1000	ng/mL
mAMP	Methamphetamines	1000	ng/mL
BAR	Barbituates	300	ng/mL
BZO	Benzodiazepines	300	ng/mL
COC	Cocaine	300	ng/mL
MTD	Methodone	300	ng/mL
PCP	Phencyclidine	25	ng/mL
THC	Marijuana Metabolites	50	ng/mL
TCA	Tricyclic Antidepressants	1000	ng/mL
OXY	Oxycodone	100	ng/mL

RUN DATE: 03/21/11 Grays Harbor Laboratory PAGE 8
RUN TIME: 1200 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: AHALL PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

Test	Day	Date	Time	Result	Reference	Units
Drug Cut-offs	1	FEB 9	1815	SEE BELOW(j)		
Drug Cut-offs	1	FEB 9	0045	SEE BELOW(k)		
Amphetamines	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Amphetamines	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Amphetamines	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Methamphetamine	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Methamphetamine	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Methamphetamine	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Barbiturates	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Barbiturates	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Barbiturates	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Benzodiazepines	4	FEB 12	1115	(l) Abn	[NEGATIVE]	
Benzodiazepines	1	FEB 9	1815	(n) Abn	[NEGATIVE]	
Benzodiazepines	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Cocaine Metab	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Cocaine Metab	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	

NOTES: (j) The following cut-off concentrations are established for the drug classes screened:

AMP	Amphetamines	1000 ng/mL
mAMP	Methamphetamines	1000 ng/mL
BAR	Barbituates	300 ng/mL
BZO	Benzodiazepines	300 ng/mL
COC	Cocaine	300 ng/mL
MTD	Methodone	300 ng/mL
PCP	Phencyclidine	25 ng/mL
THC	Marijuana Metabolites	50 ng/mL
TCA	Tricyclic Antidepressants	1000 ng/mL
OXY	Oxycodone	100 ng/mL

(k) The following cut-off concentrations are established for the drug classes screened:

AMP	Amphetamines	1000 ng/mL
mAMP	Methamphetamines	1000 ng/mL
BAR	Barbituates	300 ng/mL
BZO	Benzodiazepines	300 ng/mL
COC	Cocaine	300 ng/mL
MTD	Methodone	300 ng/mL
PCP	Phencyclidine	25 ng/mL
THC	Marijuana Metabolites	50 ng/mL
TCA	Tricyclic Antidepressants	1000 ng/mL
OXY	Oxycodone	100 ng/mL

(l) POSITIVE Abn
See also (m)

(m) This is a screening test for clinical purposes only. A more specific alternate method must be ordered for confirmation. Clinical consideration and professional judgment should be applied when interpreting this screen. If needed, confirmation must be ordered separately.

(n) POSITIVE Abn
See also (m)

Patient 2 - Healthcare Information Readily ... Age/Sex: 90/M Acct#G013321377 Unit#M0102440

RUN DATE: 03/21/11 Grays Harbor Laboratory PAGE 9
RUN TIME: 1200 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: AHALL PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readily... #G01321377 (Continued)

Test	Day	Date	Time	Result	Reference	Units
Cocaine Metab	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Methadone	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Methadone	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Methadone	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Opiates	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Opiates	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Opiates	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Phencyclidine	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Phencyclidine	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Phencyclidine	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
THC (Marijuana)	4	FEB 12	1115	(o) Abn	[NEGATIVE]	
THC (Marijuana)	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
THC (Marijuana)	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Tricycl Antidep	4	FEB 12	1115	NEGATIVE	[NEGATIVE]	
Tricycl Antidep	1	FEB 9	1815	NEGATIVE	[NEGATIVE]	
Tricycl Antidep	1	FEB 9	0045	NEGATIVE	[NEGATIVE]	
Oxycodone	4	FEB 12	1115	(q) Abn	[NEGATIVE]	
Oxycodone	1	FEB 9	1815	(r) Abn	[NEGATIVE]	
Oxycodone	1	FEB 9	0045	(s) Abn	[NEGATIVE]	

NOTES: (o) POSITIVE Abn
See also (p)
(p) This is a screening test for clinical purposes only. A more specific alternate method must be ordered for confirmation. Clinical consideration and professional judgment should be applied when interpreting this screen. If needed, confirmation must be ordered separately.
(q) POSITIVE Abn
See also (p)
(r) POSITIVE Abn
See also (p)
(s) POSITIVE Abn
TEST REPEATED POSITIVE (2-9-11 AT 1705 KK)
02/09/11 1711:
TOX OXY previously reported as: POSITIVE Ab
See also (p)

Patient: 2 - Healthcare Information Readily I... Age/Sex: 90/M Acct#G01321377 Unit#M0102440

RUN DATE: 03/21/11 Grays Harbor Laboratory PAGE 10
RUN TIME: 1200 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: AHALL PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Read... #G013321377 (Continued)

MICROBIOLOGY
BACTERIOLOGY

Specimen: 11:B0001376S COMP Collected: 02/09/11-0045 Received: 02/09/11-0052
Source: URINE Sp Descrip: STR CATH

> URINE CULTURE Final 02/12/11

COLONY COUNT	>10**5 ORGANISMS/ML
Organism 1	STAPHYLOCOCCUS AUREUS
QUANTITY	3+
GROWTH ON OXACILLIN AGAR?	CONFIRMED MRSA***

1. STAPHYLOCOCCUS AUREUS

	RX	AB Zone Sz	Target	Route	Dose
AMPICILLIN	R				
CEFUROXIME SODIUM (PARENTERAL)	R				
CEFUROXIME AXETIL (ORAL)	R				
CEFTRIAXONE	R				
CEPHALOTHIN	R				
LEVOFLOXACIN	R				
GENTAMICIN	S				
OXACILLIN/STAPH AUREUS	R				
RIFAMPIN	S				
TETRACYCLINE	S				
TRIMETHOPRIM/SULFAMETHOXAZOLE	S				
VANCOMYCIN/STAPHYLOCOCCUS	S				
NITROFURANTOIN	S				

Specimen: 11:B0001380R COMP Collected: 02/09/11-0423 Received: 02/09/11-0423
Source: SPUTUM Sp Descrip: INTUBATED

> GRAM STAIN FOR SPUTUM Final 02/09/11

WHITE BLOOD CELLS	2+
EPITHELIAL CELLS	1+
GRAM POSITIVE COCCI	2+
YEAST	1+
PSEUDOHYPHAE	2+

> SPUTUM CULTURE Final 02/12/11

Organism 1	ESCHERICHIA COLI
QUANTITY	2+
Organism 2	KLEBSIELLA PNEUMONIAE
QUANTITY	1+
Organism 3	NORMAL RESPIRATORY FLORA
QUANTITY	3+

Patient: 2 - Healthcare Information Readil... Age/Sex: 90/M Acct#G013321377 Unit#M0102440

RUN DATE: 03/21/11 Grays Harbor Laboratory PAGE 11
RUN TIME: 1200 Lab Archive System Summary Report <<< FINAL >>>
RUN USER: AHALL PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readily Ident... #G01332137 (Continued)

MICROBIOLOGY continued...
BACTERIOLOGY continued...

Specimen: 11:B0001380R COMP Collected: 02/09/11-0423 Received: 02/09/11-0423
Source: SPUTUM Sp Descrip: INTUBATED
SPUTUM CULTURE (continued)

	escco1		klpnep	
	RX	Zone Sz	RX	Zone Sz
AMOX/CLAVULANIC	S		S	24
AMPICILLIN	S		R	
AMP/SULBACTAM	S		S	
CEFUROXIME*PARE	S	25	S	28
CEFUROXIME*ORAL	S	25	S	28
CEFTRIAXONE	S	35	S	35
CEPHALOTHIN	S		S	
CIPROFLOXACIN	S		S	
GENTAMICIN	S		S	
MEZLOCILLIN	S		S	
TETRACYCLINE	S		S	
TOBRAMYCIN	S		S	
TRIMETH/SULFA	S		S	

1 ESCHERICHIA COLI

	RX	AB	Zone Sz	Target	Route	Dose
AMOXICILLIN/CLAVULANIC ACID	S					
AMPICILLIN	S					
AMPICILLIN/SULBACTAM	S					
CEFUROXIME SODIUM (PARENTERAL)	S		25			
CEFUROXIME AXETIL (ORAL)	S		25			
CEFTRIAXONE	S		35			
CEPHALOTHIN	S					
CIPROFLOXACIN	S					
GENTAMICIN	S					
MEZLOCILLIN	S					
TETRACYCLINE	S					
TOBRAMYCIN	S					
TRIMETHOPRIM/SULFAMETHOXAZOLE	S					

2 KLEBSIELLA PNEUMONIAE

	RX	AB	Zone Sz	Target	Route	Dose
AMOXICILLIN/CLAVULANIC ACID	S		24			
AMPICILLIN	R					
AMPICILLIN/SULBACTAM	S					
CEFUROXIME SODIUM (PARENTERAL)	S		28			
CEFUROXIME AXETIL (ORAL)	S		28			
CEFTRIAXONE	S		35			
CEPHALOTHIN	S					
CIPROFLOXACIN	S					
GENTAMICIN	S					
MEZLOCILLIN	S					
TETRACYCLINE	S					
TOBRAMYCIN	S					
TRIMETHOPRIM/SULFAMETHOXAZOLE	S					

Patient: 2 - Healthcare Information Readil... Age/Sex: 90/M Acct#G01332137 Unit#M0102440

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

MICROBIOLOGY continued...
BACTERIOLOGY continued...

Specimen: 11:B0001381R COMP Collected: 02/09/11-0805 Received: 02/09/11-0849
Source: NARES Sp Descrip: BOTH

> MRSA SCREEN Final 02/11/11
NEGATIVE for Methicillin Resistant Staph aureus

RUN DATE: 03/21/11
RUN TIME: 1200
RUN USER: AHALL

Grays Harbor Laboratory
Lab Archive System Summary Report <<< FINAL >>>
PCI User: AHALL Lab Database: LAB.GRY

Patient: [redacted] #G013321377 (Continued)

MICROBIOLOGY continued...

**********BLOOD CULTURE**********

Specimen: 11:BC0000663S COMP Collected: 02/09/11-0040 Received: 02/09/11-0118
Source: BLOOD Sp Descrip: VENOUS
> BLOOD CULTURE [redacted] Final 02/14/11
NO GROWTH AT 5 DAYS.

Specimen: 11:BC0000664S COMP Collected: 02/09/11-0050 Received: 02/09/11-0118
Source: BLOOD Sp Descrip: VENOUS
> BLOOD CULTURE [redacted] Final 02/14/11
NO GROWTH AT 5 DAYS.

Patient: 2 - Healthcare Information Readil... #G013321377 (Continued)

<<<CANCELLED SPECIMENS>>>

0209:CB00002S CAN, Coll: 02/09/11-0045 Recd: - (R#01226825) BUCK,JULIE M
Ordered: BMPwCAI
Comment: No green top tube submitted.
0209:C00125U CAN, Coll: 02/09/11-2000 Recd: - (R#01227008) GIVENS,BARBARA
Ordered: TROP T
Comment: COMBINED ORDERS

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

February 24, 2011

Mr. & Mrs. Ron & Valerie Foulds, Jr.
712 Spruce St
Hoquiam, WA 98550

COPY

RE: Unknown Respondent
Case No. 2011-153821MD

Dear Mr. & Mrs. Foulds:

Thank you for your recent letter in which you express concerns regarding medical care provided by an Unknown Respondent. Your complaint has been assigned case number 2011-153821MD.

Your complaint will be investigated to determine if a violation of the Uniform Disciplinary Act, RCW 18.130.180, Unprofessional Conduct, has occurred. If you have any additional information pertaining to your complaint, please forward it along with a copy of this letter to me at the address listed below. Please understand that you may not hear from us during the investigation. If we need additional information from you, one of the Commission's investigators will contact you.

Enclosed for your information is the brochure, *What Happens Next?* along with a copy of RCW 18.130.180, the statute that identifies Unprofessional Conduct. Once the investigation is complete, a panel of the Medical Quality Assurance Commission will review the facts of the case and make a decision. You will be notified in writing of the decision.

Thank you for bringing your concerns to the attention of the Medical Quality Assurance Commission. If you have any questions or need additional information, please call me at 360-236-2770.

Sincerely,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98506-7866

Enclosures: What Happens Next?
RCW 18.130.180

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

February 24, 2011

Ron & Valerie Foulds, Jr.
712 Spruce St
Hoquiam, WA 98550

RE: Unknown Respondent
Case No. 2011-153821MD

COPY

Dear Mr. & Mrs. Foulds:

Washington state law, RCW 43.70.075, pertains to the "Whistleblower Law" which requires that the identity of a complainant/whistleblower who complains in good faith to the Department of Health about improper quality of care by a health care provider shall be kept confidential. In some instances, particularly in your case, where you are the consumer of care complaining against a provider, an investigation cannot proceed without disclosure of your identity to the particular provider. This is so the provider can respond appropriately to the allegations of your complaint and provide records specific to your complaint.

This investigation and/or action is contingent upon the disclosure of your identity to the provider. Should you desire this investigation to proceed, your voluntary authorization in the form of an Authorization to Release Complainant's Name will be necessary. I have enclosed this form for your signature, along with a postage paid envelope for its return. Once your waiver is received, your identity will be released solely for the purposes of investigation and adjudication as necessary. Your identity will be protected in all other instances and will not be released in response to public disclosure requests. ***Your signed waiver is due back by no later than March 10, 2011.***

If you have any questions, please contact me at (360) 236-2770.

Thank you for your cooperation.

Sincerely,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission
Medical Investigations
PO Box 47866
Olympia, WA 98504-7866

Attachments: Return Envelope
Waiver of Confidentiality of Identity

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
* * * * *

COPY

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides In part: "The Identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential."

I understand that my identity is confidential pursuant to RCW 43.70.075, unless waived.

By signing this document, I waive my right to confidentiality and authorize the Department of Health to release my identity to **UNKNOWN** respondent, and to other persons who are reasonably necessary to the investigation, and for use in any subsequent administrative proceeding regarding my complaint. I understand that my identity will not be released for any other purpose.

APPROVAL OF CONFIDENTIALITY WAIVER

For the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings, I hereby waive confidentiality and consent to the release of my identity.

Signature:_____ **Printed name:** _____
Date:_____ Please include middle initial
Home Phone:_____ **Date of Birth:** _____
Day Phone:_____ ***PLEASE RETURN NO LATER THAN March 10, 2011***

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-153821MD
RESPONDENT: UNKNOWN

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Aging and Disability Services Administration
PO Box 45600, Olympia, Washington 98504-5600

February 16, 2011

VALERIE FOULDS
712 Spruce Street
Hoquiam, WA 985502218

RE: MONTESANO HEALTH & REHAB CENTER

Dear VALERIE FOULDS:

Thank you for contacting the Complaint Resolution Unit (CRU) hotline in Residential Care Services (RCS) with your concerns about the facility/provider referenced above. RCS is part of the Department of Social & Health Services (DSHS), and is responsible for the licensing and/or certification of supported living, nursing homes, boarding homes, adult family homes, and institutions for persons with mental retardation in Washington State. RCS investigates complaints in all of these settings.

To help you better understand what you can expect from us, we've enclosed a fact sheet about RCS Complaint Investigations.

Staff in the CRU enters the information from your message, and any follow-up conversations about that message, onto an intake form. Registered nurses that work in the CRU review the intake and determine how quickly RCS needs to respond with an investigation. After this priority is established, CRU sends the intake to a regional field office. This office is where the complaint investigators are physically located, and those investigators will be the ones to go to the facility to look into the potential regulatory issues that are part of your report.

If you left your name and telephone number with the CRU when you called, and gave permission to be contacted, the regional field investigator will also call you to review your concerns before going to the facility or home.

The control number assigned to your concerns is 11-02-04370.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
* * * * *

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential."

I understand that my identity is confidential pursuant to RCW 43.70.075, unless waived.

By signing this document, I waive my right to confidentiality and authorize the Department of Health to release my identity to **UNKNOWN** respondent, and to other persons who are reasonably necessary to the investigation, and for use in any subsequent administrative proceeding regarding my complaint. I understand that my identity will not be released for any other purpose.

APPROVAL OF CONFIDENTIALITY WAIVER

For the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings, I hereby waive confidentiality and consent to the release of my identity.

Signature: Ronald Foulks JR **Printed name:** Ronald Foulks JR
Please include middle initial
Date: 3/6/11
Home Phone: 1-360-533-5767 **Date of Birth:** 9/18/54
Day Phone: 1-360-533-5767
PLEASE RETURN NO LATER THAN March 10, 2011

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-153821MD
RESPONDENT: UNKNOWN

RECEIVED
MAR 09 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Medical Quality Assurance Commission
Medical Investigations

P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of Health

Fax

Date: 03/16/11

Number of pages including cover sheet: 2

To:Gray's Harbor Comm.Hosp ROI

Phone: 360-537-5000

Fax: 360-537-5004

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

RE: WA State Medical Quality Assurance Commission Investigation/
File # 2010-151650MD

Dear Medical Record Technician:

This letter identifies documentation needed in the investigation regarding the care of 2 - Healthcare Information Readily ... . This is a request for medical records. Your input will be of great assistance in the conduct of this investigation.

The Medical Quality Assurance Commission is the agency within the State government with legislated authority to assure the delivery of safe health care. Under provision of RCW 18.130.050 and RCW 18.130.160 of the Uniform Disciplinary Act, the Medical Quality Assurance Commission is empowered to investigate all allegations and complaints to determine whether such allegations are substantiated and to take disciplinary or corrective action If It is warranted.

Be advised that this is a preliminary investigation and no charges against the licensee have been issued In connection with this investigation.

The Health Care Information Act, RCW 70.02.050 (2) (a) authorizes and requires a health care provider to disclose health care information concerning a patient(s) without the patient's authorization when needed to determine compliance with state licensure regulations and laws, or when needed to protect the public health. Pursuant to the health care Information act, compulsory process (subpoena) Is no longer required to obtain health care information.

Under provisions of the above laws, you are requested to provide the following: The 02/08/11 ER report, the H&P/Discharge reports for 2 - Healthcare Information Readily Identifiabl... (DOB 2 - Healthcar...) 02/08/11-02/14/11 admission, all urine toxicology reports.

Please send the requested documentation to the address below or fax it to (360) 236-2795 **within 14 days**. Note: If there is a charge for the copying of the records, please Include your **federal tax identification number** on your billing statement. If copying costs will exceed $100.00, please advise before copying. ATTN: Connie Pyles, Health Care Investigator. If you have any questions concerning this request, please contact me at (360) 236-2776. Thank you for your cooperation.

Sincerely,

Connie Pyles
Health Care Investigator
Medical Quality Assurance Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

ATTENTION: The information in this fax message is privileged and confidential. It is intended only for the use of the recipient named above (or the employee or agent responsible to deliver it to the intended recipient). If you received this in error, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you *have* received this message in error, please notify us by telephone immediately, and return the original message to us at the address listed above via U.S. Postal Service. We will, of course, be happy to reimburse you for any costs. Thank you.

RE: WA State Medical Quality Assurance Commission Investigation
File # 2010-151650MD

Dear Medical Record Technician:

This letter identifies documentation needed in the investigation regarding the care of 2 - Healthcare Information Readily Id... This is a request for medical records. Your Input will be of great assistance in the conduct of this investigation.

The Medical Quality Assurance Commission is the agency within the State government with legislated authority to assure the delivery of safe health care. Under provision of RCW 18.130.050 and RCW 18.130.160 of the Uniform Disciplinary Act, the Medical Quality Assurance Commission is empowered to investigate all allegations and complaints to determine whether such allegations are substantiated and to take disciplinary or corrective action if It Is warranted.

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Sincerely,

Connie Pyles
Health Care Investigator
Medical Quality Assurance Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1201
RECIPIENT ADDRESS	8p36053750045203901
DESTINATION ID	
ST. TIME	03/16 10:50
TIME USE	00'24
PAGES SENT	2
RESULT	OK

Medical Quality Assurance Commission
Medical Investigations

P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of
Health

Fax

Date: **03/16/11**

Number of pages including cover sheet: **2**

To:Gray's Harbor Comm.Hosp ROI

Phone: 360-537-5000

Fax: 360-537-5004

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1199
RECIPIENT ADDRESS	8p36053750045203901
DESTINATION ID	
ST. TIME	03/16 07:39
TIME USE	00'18
PAGES SENT	2
RESULT	OK

Medical Quality Assurance Commission
Medical Investigations

P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of
Health

Fax

Date: 03/16/11

Number of pages including cover sheet: 2

To:Gray's Harbor Comm.Hosp ROI

Phone: 360-537-5000

Fax: 360-537-5004

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

Grays Harbor COMMUNITY HOSPITAL

Fax Transmittal

DATE: 3-21-11

TO: Connie Pyles

FAX #: 360-236-2795

FROM: GHCH Health Information - Alesia

FAX #: 360-537-0588

PHONE #: 360-537- 0585

PAGES FAXED: 37 (including cover sheet) Please advise as soon as possible if all pages are not received.

MESSAGE:

Initiation Date: June, 2010

Medical Quality Assurance Commission
Medical Investigations
P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of Health

Fax

Date: 03/16/11

Number of pages including cover sheet: 2

To:Gray's Harbor Comm.Hosp ROI

Phone: 360-537-5000

Fax: 360-537-5004

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

M1024440

RE: WA State Medical Quallly Assurance Commission Investigation/
File # 2010-161650MD

Dear Medical Record Technician:

This letter identifies documentation needed in the investigation regarding the care of 2 - Healthcare Information Readily I... This is a request for medical records. Your input will be of great assistance in the conduct of this investigation.

The Medical Quality Assurance Commission is the agency within the State government with legislated authority to assure the delivery of safe health care. Under provision of RCW 18.130.050 and RCW 18.130.160 of the Uniform Disciplinary Act, the Medical Quality Assurance Commission is empowered to investigate all allegations and complaints to determine whether such allegations are substantiated and to take disciplinary or corrective action if it is warranted.

Be advised that this is a preliminary investigation and no charges against the licensee have been issued in connection with this investigation.

The Health Care Information Act, RCW 70.02.050 (2) (a) authorizes and requires a health care provider to disclose health care information concerning a patient(s) without the patient's authorization when needed to determine compliance with state licensure regulations and laws, or when needed to protect the public health. Pursuant to the health care information act, compulsory process (subpoena) is no longer required to obtain health care information.

GH13321317

Under provisions of the above laws, you are requested to provide the following: The 02/08/11 ER report, the H&P/Discharge reports for 2 - Healthcare Information Readily Identifiab... (DOB 2 - Healthcar...) 02/08/11-02/14/11 admission, all urine toxicology reports.

Please send the requested documentation to the address below or fax it to (360) 236-2795 within 14 days. Note: If there is a charge for the copying of the records, please include your federal tax identification number on your billing statement. If copying costs will exceed $100.00, please advise before copying. ATTN: Connie Pyles, Health Care Investigator. If you have any questions concerning this request, please contact me at (360) 236-2776. Thank you for your cooperation.

Sincerely,

Connie Pyles
Health Care Investigator
Medical Quality Assurance Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

****
*** RX REPORT ***
****

RECEPTION OK

TX/RX NO	8732
RECIPIENT ADDRESS	
DESTINATION ID	
ST. TIME	03/21 12:20
TIME USE	07'17
PGS.	37
RESULT	OK

Medical Quality Assurance Commission
Medical Investigations

P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of Health

Fax

Date: 03/21/11

Number of pages including cover sheet: 3

To:Montesano Health and Rehab

Attn: Kathy Stone, DNS

Phone: 360-249-2273

Fax: 360-249-2363

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

RE: WA State Medical Quality Assurance Commission Investigation/
Flle # 2011-153821MD

Dear Kathy:

Thank you for speaking with me today. This letter Identifies documentation needed in the investigation regarding the care of 2 - Healthcare Information Readily I... This Is a request for medical records. Your input will be of great assistance in the conduct of this investigation.

The Medical Quality Assurance Commission is the agency within the State government with legislated authority to assure the delivery of safe health care. Under provision of RCW 18.130.050 and RCW 18.130.160 of the Uniform Disciplinary Act, the Medical Quality Assurance Commission is empowered to Investigate all allegations and complaints to determine whether such allegations are substantiated and to take disciplinary or corrective action If it is warranted.

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Under provisions of the above laws, you are requested to provide the following: The patient/provider encounters with 2 - Healthcare Information Readily I... (DOB 2 - Healthcar... from 01/01/11 to the present, the physician orders from 01/01/11 to the present, the MAR for Mr. 2 - Healt... from Jan-March, 2011, the findings/report from the 02/08/11 incident, copy of Narcotics Log Book indicating reconciliation for 02/08/11 meds

Please send the requested documentation to the address below or fax it to (360) 236-2795 **within 14 days.** Note: If there Is a charge for the copying of the records, please include your **federal tax identification number** on your billing statement. If copying costs will exceed $100.00, please advise before copying. ATTN: Connie Pyles, Health Care Investigator. If you have any questions concerning this request, please contact me at (360) 236-2776. Thank you for your cooperation.

Sincerely,

Connie Pyles
Health Care Investigator
Medical Quality Assurance Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
STATEMENT FORM

File Number: 2011-153821 MD

Statement of: LAURIE JUSTICE

Location where statement is taken: _____

Statement: _____

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed: _____ Date: _____

Name: _____ Time: _____

Address: _____ City, Zip: _____

Telephone: (____) _____ Witness: _____

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1210
RECIPIENT ADDRESS	8p36024923635203901
DESTINATION ID	
ST. TIME	03/21 13:27
TIME USE	00'30
PAGES SENT	3
RESULT	OK

Medical Quality Assurance Commission
Medical Investigations

P.O. BOX 47866
OLYMPIA, WASHINGTON 98504-7874

Washington State Department of Health

Fax

Date: 03/21/11

Number of pages including cover sheet: 3

To:Montesano Health and Rehab
Attn: Kathy Stone, DNS

Phone: 360-249-2273

Fax: 360-249-2363

CC:

From: Connie Pyles, Health Care Investigator

Phone: 360-236-2776

Fax phone:360-236-2795

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

RE: WA State Medical Quality Assurance Commission Investigation/
File # 2011-153821MD

Dear Kathy:

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Please send the requested documentation to the address below or fax it to (360) 236-2795 **within 14 days.** Note: If there is a charge for the copying of the records, please include your federal tax identification number on your billing statement. If copying costs will exceed $100.00, please advise before copying. ATTN: Connie Pyles, Health Care Investigator. If you have any questions concerning this request, please contact me at (360) 236-2776. Thank you for your cooperation.

Sincerely,

Connie Pyles
Health Care Investigator
Medical Quality Assurance Commission
Department of Health
P.O. Box 47666
Olympia, WA 98504-7866

Case File_5738_pdf-r.pdf redacted on: Tuesday, September 18, 2012

Redaction Summary (263 redactions)

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2 Privilege / Exemption reasons used:

1 -- "Attorney Work Product - RCW 42.56.290" (1 instance)

2 -- "Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1)" (262 instances)

Redacted pages:

Page 5, Attorney Work Product - RCW 42.56.290, 1 instance
Page 7, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 6 instances
Page 8, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 11 instances
Page 16, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 24, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 27, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 6 instances
Page 28, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 4 instances
Page 29, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 32, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 34, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 3 instances
Page 40, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 41, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 42, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 43, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 44, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 45, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 49, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 6 instances
Page 50, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 4 instances
Page 51, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 52, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 56, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 4 instances
Page 57, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 58, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 60, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 61, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 62, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 73, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 16 instances
Page 74, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 13 instances
Page 75, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 76, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 77, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance

Page 78, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 79, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 80, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 81, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 82, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 84, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 85, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 86, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 87, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 88, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 89, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 90, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 91, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 92, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 93, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 94, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 95, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 96, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 97, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 98, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 99, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 100, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 101, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 102, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 103, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 104, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 105, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 106, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 107, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 108, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 109, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 110, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW

42.56.070(1), 2 instances
Page 111, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 112, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 113, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 114, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 115, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 116, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 117, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 118, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
Page 119, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 1 instance
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Page 122, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 123, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
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Page 126, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 127, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 128, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 129, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 20 instances
Page 130, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 131, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 132, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
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Page 138, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
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Page 152, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 153, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 154, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 155, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 156, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 157, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 158, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 159, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 2 instances
Page 166, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 3 instances
Page 167, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 3 instances
Page 172, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 3 instances
Page 175, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 4 instances
Page 178, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 4 instances